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Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain [out-of-pocket costs](#), like a [copayment](#), [coinsurance](#), or [deductible](#). You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services: If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

In New York State, If you are uninsured or your employer or union self-insures, you may file a dispute through the independent dispute resolution (IDR) process if you receive a bill for emergency services in New York that you believe is excessive. You will have to pay the fee for the IDR if your provider's bill is upheld unless your household income is below 250% of the Federal Poverty Level.

Complete an IDR Patient Application and send it to NYS Department of Financial Services, Consumer Assistance Unit/IDR Process, One Commerce Plaza, Albany, NY 12257.

Your provider will only bill you for your in-network copayment, coinsurance, or deductible for emergency services, including inpatient services which follow an emergency room visit, if you have coverage through an HMO or insurer subject to NY law (coverage that is not self-insured) and you:

- **Sign AOB Form** Sign an Assignment Of Benefits form to allow your provider to request payment from your health plan; AND
- **Send AOB Form and Bill** Send the assignment of benefits form to your health plan and provider and include a copy of the bill you do not think you should pay.

Certain services at an in-network hospital or ambulatory surgical center: When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can’t balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can’t** balance bill you, unless you give written consent and give up your protections.

You’re never required to give up your protections from balance billing. You also aren’t required to get out-of-network care. You can choose a provider or facility in your plan’s network.

Consumers in New York are protected from surprise bills when treated by an out-of-network doctor at a participating hospital or ambulatory surgical center in their health plan’s network. Additionally, consumers with health insurance coverage provided by an insurer or HMO are protected from surprise bills when a participating doctor refers them to a non-participating provider.

When balance billing isn’t allowed, you also have these protections:

- You’re only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - Cover emergency services without requiring you to get approval for services in advance (also known as “prior authorization”).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you’ve been wrongly billed, contact NYS Department of Financial Services 1-800-342-3736 or e-mail Surprisemedicalbills@dfs.ny.gov. To submit a dispute, you must complete an IDR Patient Application and send it to NYS Department of Financial Services, Consumer Assistance Unit/IDR Process, One Commerce Plaza, Albany, NY 12257.

Received By: _____ Date: _____