Balance Billing & Surprise Billing

Quick Facts and Information for Granite Staters

What is balance billing?

Don't be confused! **Balance billing** is just a technical term used to describe **the amount of money you owe for medical care after the insurance company pays its portion.** This amount includes your cost-sharing obligations defined in your health plan, such as your copay, coinsurance, the deductible amount, or even the full cost of the service, depending on the arrangement between your insurance company and the provider.

How is the balance calculated?

It's simple! **The amount you owe is calculated by taking the cost of the medical care you received and subtracting the amount of money paid by your insurance company.** To better understand how much you will be responsible for paying, based on the type of medical care you're received, contact your insurance company.

What is surprise billing?

Surprise billing is an unexpected charge for medical care that you may be fully responsible for paying, even if you received treatment through an in-network provider or facility. For example: If you received treatment in an Emergency Room at an in-network hospital for a heart attack, the anesthesiologist who administered anesthesia may not be considered in-network for your insurance. As such, your anesthesiologist may try to bill you for the full cost of the anesthesiologist services, even though you received life-saving care and couldn't select an in-network doctor.

Good news! A new law protects you from surprise billing.

Effective July 1, 2018, **a law was enacted to protect you from surprise billing by certain providers.** The goal of this new law is to protect consumers by requiring care providers and insurance companies to hold the consumer harmless for balance bill charges. More specifically:

If you received care at an in-network hospital or surgical center, the new law prevents anesthesiology, radiology, emergency medicine, or pathology service providers—even if those providers are not in-network for your insurance plan—from charging you anything other than your standard copays, deductibles, or coinsurance.

GLOSSARY OF IMPORTANT TERMS:

In-Network Provider:

Most health insurance plans have a network of contracted facilities, doctors, and other medical providers who have agreed to provide services to their members at an agreed upon rate. The providers in the plan's provider network are considered "in-network." The important thing for you to remember is that you'll usually pay lower out-of-pocket costs when you receive services from in-network entities.

Out-of-Network Provider:

The facilities, doctors and other medical providers, pharmacies, and suppliers that do not have a contract with your health insurance plan to provide care to you are considered out-of-network. You will pay more for healthcare services received out of network than services received in-network.

Payment Responsibility:

This is the amount of money you, the patient, is expected to pay, such as copays, deductibles, and coinsurance.

Non-Participating Facility-Based Providers:

This describes health care providers who are associated with an in-network facility yet are not contracted with your insurance company. These providers sometimes include anesthesiologists, radiologists, and pathologists.

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I have more questions.

Who can help me?

CONTACT YOUR HEALTH INSURANCE COMPANY.

You'll find their phone number on the back of your insurance card or visit their website.

CONTACT THE NH INSURANCE DEPARTMENT CONSUMER SERVICES DEPARTMENT.

- (603) 271-2261
- (800) 852-3416
- (800) 735-2964 (TYY/RDD Relay Services)
- consumerservices@ins.nh.gov
- www.NH.gov/insurance

This document is for informational purposes only. While the New Hampshire Insurance Department has made every effort to provide accurate information, some information has been generalized. Please contact your health insurance company to obtain specific information about your policy.