

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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, such as a copayment, coinsurance, and/or a deductible. You may have other 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” describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay 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 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.

Services may be performed in the hospital by in-network providers as well as out-of-network providers who may separately bill the patient. Providers who perform health care services in the hospital may or may not participate in the same health benefits plans as the hospital. You should contact your health insurance carrier in advance of receiving services at the hospital to determine whether the scheduled health care services will be covered at in-network rates.

Please [click here](#) for a list of health insurance companies that have contracts with the hospital.

You are 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 the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). 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.

New Mexico law also protects patients from balance billing for out-of-network emergency care. Patients are protected from paying more than the cost-sharing obligation that would apply for the same services if they had been rendered by an in-network provider.

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 may 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 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 care out-of-network. You can choose a provider or facility in your plan's network.

New Mexico law also protects patients from balance billing for non-emergency care rendered by an out-of-network provider at an in-network facility, if the patient does not have the ability or opportunity to choose an in-network provider who is available to provide the care, or medically necessary care is unavailable within a plan's network. Patients are protected from paying more than the cost-sharing obligation that would apply for the same services if they had been rendered by an in-network provider. The protections do not apply if a patient has knowingly chosen

to receive the care from an out-of-network provider.

Other protections against balance billing under New Mexico law include the following:

- Any written letter, other than a receipt of payment, sent from a health care provider or health insurance company about a surprise bill will clearly state that a patient has to pay only the amount of the co-payments, deductible, or other cost-sharing amounts.
- If a surprise bill is sent to a person with health insurance, that individual may file a complaint about the health insurance company's decision regarding a surprise bill.
- A health insurance company cannot require that a patient get prior authorization to receive care from an out-of-network provider for emergency care before the patient is stabilized.
- An individual with health insurance will be told that a provider is out-of-network before services are provided to that individual under nonemergency circumstances, and the individual will be told to contact their health insurance company to discuss their options. If the patient agrees to receive services from an out-of-network provider, then that provider can bill for charges not covered by your insurance company.
- If a patient with health insurance pays an out-of-network provider for a surprise bill (more than the applicable co-payment, deductible, or other cost-sharing amount), the out-of-network provider will refund the amount of the overpayment.
- If a patient with insurance is not refunded an overpayment by an out-of-network provider within 45 days, the patient may ask for their refund from their out-of-network provider, plus interest, by filing a complaint with the New Mexico Insurance Department.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- In general, your health plan must:
 - Cover emergency services without requiring you to get approval for services in advance (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 deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the No Surprises Help Desk, operated by the Department of Health and Human Services' Centers for Medicare and Medicaid Services, at 1-800-985-3059, or the New Mexico Office of Superintendent of Insurance at 1-855-4-ASK-OSI (1-855-427-5674) or by completing a complaint form at <https://www.osi.state.nm.us/index.php/managed-healthcare-complaint/>.

Visit <https://www.cms.gov/nosurprises/consumers> for more information about your rights under federal law.

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