Price Estimates & Cost Calculator

Beginning Jan. 1, 2019, the U.S. Department of Health & Human Services and Centers for Medicare & Medicaid Services require hospitals and health systems to post their "current, standard charges."

On this page, you can access the standard prices, or charges, for the Mobridge Regional Hospital.

Please note: The prices listed are the amounts Mobridge Regional Hospital would bill an insurer. The amounts are not representative of a patient's expected out-of-pocket costs. Because each patient's case is different based on specific medical conditions, the actual amount owed by a patient will depend on that patient's insurance coverage.

The prices listed were in effect as of January 1, 2021.

Hospital charges are the amount a hospital bills the patients' insurance company for a service. For most patients, hospitals are reimbursed at a level well below charges. Patients covered by commercial insurance have negotiated rates with hospitals. Patients covered by Medicare or Medicaid programs have hospital reimbursement rates determined by federal and state governments. Patients should talk with their insurance provider to understand which costs will be covered, and which will be the patient's responsibility.

Hospital charges may also include bundled rates for procedures, personnel, services, and supplies. For example, room rates may include the space, equipment, nursing personnel, and supplies.

Mobridge Regional Hospital has established a process to help patients find out what an anticipated visit or procedure would cost. For quick, clear answers to questions about billing, payments, insurance and more, call us at (605) 845-3692. Our business office hours are 8 am - 4:30 pm Monday-Friday.

Disclaimer: The information provided is a comprehensive list of charges for each inpatient and outpatient service or item provided by Mobridge Regional Hospital, also known as a chargemaster. It is not a helpful tool for patients to comparison shop between hospitals or to estimate what health care services are going to cost you as a patient for out-of-pocket expenses.

No Surprise Billing

When you receive emergency care or are 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 must 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.

For more information, please view our No Surprises Disclosure Notice.

Mobridge Regional Hospital and Clinics

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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 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 must 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.

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 plans 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 balanced billed for these post stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or an ambulatory surgical center, certain providers in these separate locations 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.

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

1. 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.

2. Your health plan generally must:
   a. Cover emergency services without requiring you to get approval for services in advance (prior authorization).
   b. Cover emergency services by out of network providers.
   c. 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.
   d. 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 1-800-985-3059.

Visit https://www.cms.gov/nosurprisesfor more information about your rights under federal law.