

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 or balance billing.

What is balance billing (sometimes called surprise billing)?

When you see a doctor or healthcare provider, you may owe certain out of pocket costs, such as copayment, coinsurance, and/or deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a healthcare 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 the 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 copayment or coinsurance). You can't be balance billed for 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.

(continued on reverse)

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 the 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:

- You are only responsible for paying your share of the cost (like 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.
- Your health plan generally 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 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 Department of Health and Human Services at **(800) 985-3059**.

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

