Your Rights and Protections Against Surprise Medical Bills

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

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

When you see a health care provider, you may owe out-of-pocket costs (copayments, coinsurances, deductibles). If the provider or facility is not in your plan's network, you may have to pay more costs or the entire bill. "Out-of-network" providers may 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 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 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 they may bill you is your plan's in-network cost-sharing (i.e., copayments, coinsurance). You **can't** be balance billed for these emergency services. This includes services after you're stable, 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.** Certain providers at an in-network hospital or ambulatory surgical center may be out-of-network. The most those providers may bill you is your plan's in-network cost-sharing. 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 from balance billing. 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 <u>never</u> required to give up your protection from the balance billing described above.
If you choose an in-network provider or facility, you will not be balance billed.

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

You are only responsible for paying your share of the cost (copayments, coinsurance, and deductibles) you would pay if the provider or facility were in-network. Your health plan will pay out-of-network providers and facilities directly. Your health plan will:

- Cover emergency services without requiring approval in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (your cost-share) on what the plan would pay an in-network provider and show that amount in your explanation of benefits.
- Count amounts 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 U.S. Department of Health and Human Services (HHS) at 1-800-985-3059. Visit <u>www.cms.gov/nosurprises/consumers</u> for more information about your rights under federal law.