



Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at a 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 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 a network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

1. **Emergency Care:** 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 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.
2. **Certain services at a network hospital or ambulatory surgical center:** When you get services from a network hospital or ambulatory surgical center, certain providers there may be out-of-network. These providers are not allowed to send you a balance bill and they may not ask you to surrender your protection against being balance billed. If you receive other services at these network facilities, other types of out-of-network providers cannot send you a balance bill unless you have given them written consent ahead of time waiving your protections.

You're never required to surrender your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in the network.

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

- a) 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). The medical plan will pay out-of-network providers and facilities directly.
- b) The plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization or precertification).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay a 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 and would like to submit a complaint regarding potential violations of your balance billing protections, you may contact the federal Department of Health and Human Services:

- Phone number for information and complaints: 1-800-985-3059
- Website: <https://www.cms.gov/nosurprises/consumers>