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YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

Starting on January 1, 2022, when you get emergency care (other than ground ambulance services) 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 an out-of-network provider or visit an out of network health care facility.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. This means that they have not agreed in advance to accept payment at discounted rates for providing healthcare services. Out-of-network providers may bill you for the difference between what your plan agreed to pay and the non-discounted amount the provider charges for a service. This practice is called "**balance billing**." The amount billed by an out-of-network provider or facility is often more than the cost of the same services provided in-network based on contracted rates and the amount charged above in-network rates in these situations may 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 many emergency situations 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 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 balanced billed for post-stabilization services (services provided after patient is stable, such as a post-emergency hospital stay). This protection against balance billing also includes charges from out-of-network air ambulance providers for emergency services, but does not include protection against balance billing on charges from out-of-network ground ambulance providers that you may call when you have an emergency.

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

When you get services at an in-network hospital or ambulatory surgical center, some providers there may be out-of-network. In those cases, the most the out-of-network 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 protection 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 protection.

You're never required to give up your protections from balance billing. You are also not 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 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.

- Your health plan generally must cover the following with regard to healthcare services that protect the patient from balance billing under the law:

    - Cover emergency services without requiring you to get approval for services in advance (which is also called prior authorization).

    - Cover emergency services by out-of-network providers.

    - Calculate your cost-sharing (what you owe the provider or facility) based on what it would pay an in-network provider or facility and show that amount in your explanation of benefits (EOB).

    - Count any amount you pay for emergency services or services you receive from out-of-network providers while in an in-network facility toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the No Surprises Help Desk at 1-800-985-3059.

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