

Your rights and protections against surprise medical bills



When you get emergency care or get treated by a non-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 co-payment, co-insurance, 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.

“Non-network,” sometimes also referred to “out-of-network,” describes providers and facilities that haven't signed a contract with your health plan. Non-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, such as in an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by a non-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from a non-network provider or facility, the most the provider or facility can bill you is your plan's in-network cost-sharing amount (such as co-payments and co-insurance). You **cannot** be balance billed for these emergency services. This includes services you may receive 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.

Certain services at a Network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be non-network. In these cases, the most those providers can 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 **cannot** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you receive other services at these in-network facilities, non-network providers **cannot** 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 receive out-of-network care. 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 co-payments, co-insurance and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay non-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 non-network providers.
 - 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.

- Count any amount you pay for emergency services or non-network services toward your deductible and out-of-pocket limit.

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