Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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, like a copayment, coinsurance, or deductible. You may have additional 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" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of- network providers may be allowed to 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 plan's deductible or 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

For emergency services from an out-of-network provider, you can only be charged your plan's in-network cost-sharing and cannot be balance billed, including post-stabilization care unless you give written consent.

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

When you receive care at an in-network hospital or surgical center, certain out-of-network providers may be involved, but they can only charge your in-network cost-sharing and cannot balance bill you for covered services.

If you get other types of 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 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 these protections:

You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly. Generally, your health plan must:

- Cover emergency services without requiring you to get approval for services in advance.
- Cover emergency services by out-of-network providers.
- Base claim payment on in-network rates and show that amount on your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket.

If you think you've been billed incorrectly:

If you have a question, complaint, or dispute regarding the insurance coverage you get through your employer, first contact your Human Resources Department or the benefits contact at your employer.

If you need additional support, contact the Department of Insurance for your state of residence. You may also contact the U.S. Department of Health & Human Services at 800-985-3059.