

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care 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, 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.

Who DOES surprise billing apply to?

- Individuals who have health insurance coverage through an employer, a Health Insurance Marketplace or an individual health plan purchased directly from an insurance company.

Who DOESN’T surprise billing apply to?

- Government funded programs such as Medicare, Medicaid, Children's Health Insurance Program (CHIP), or TRICARE. Many Government funded programs already have protections in place and are not part of the surprise billing law.

You’re 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 can bill you is your plan’s in-network cost-sharing amount (such as copayments, coinsurance, and deductibles).
- 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.
- Please note that the States of Illinois and Missouri have State balance billing laws or requirements. Contact information and available resources are as follows:

The Illinois Department of Insurance

Phone: 1-877-527-9431

website: <https://www2.illinois.gov/sites/Insurance/consumers/Pages/default.aspx>

Missouri Department of Insurance

Address: PO Box 690, Jefferson City, MO 65102-0690

Telephone: 1-800-726-7390

Email: news@difp.mo.gov

website: <https://insurance.mo.gov/consumers/health/managingcost.php>

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

- When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-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 can't balance bill you and may not ask you to give up your protections not to be balance billed.
- 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 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 is 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 (also known as "prior authorization").
 - Cover emergency services by out-of-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 out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, you may contact the Centers for Medicare and Medicaid Services at 1-800-985-3059.

Visit [Consumers | CMS](#) for more information about **your rights under federal law** and/or file a complaint with your State balance billing regulator, if any, which is identified below:

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website: <https://www2.illinois.gov/sites/Insurance/consumers/Pages/default.aspx>

Missouri Department of Insurance

Address: PO Box 690, Jefferson City, MO 65102-0690

Telephone: 1-800-726-7390

Email: news@difp.mo.gov

website: <https://insurance.mo.gov/consumers/health/managingcost.php>

To learn more and get a form to start the process or more information about your right to a Good Faith Estimate or the dispute process go to [Consumers | CMS](#) or call 1-800-985-3059.