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 healthplan to provide services. Out-of-network providers may be allowed to bill you for the differencebetween 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

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 balanced billed for thesepost-stabilization services.

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 isyour 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 protectionsnot 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 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.

If you are a Virginia resident, Virginia law addresses surprise billing in the following ways:

- Insurers are required to tell you which providers and facilities are in their networks.
- Providers and facilities must tell you with which provider networks they participate. This information is available upon request.
- Virginia's Balance Billing Protection covers fully-insured policies issued in Virginia; Virginia state employee health benefit plans; and self-funded groups that opted-in to offer the Virginia balance

billing protections to their enrollees.

- If you pay an out-of-network provider an amount that exceeds your in-network cost-sharing requirement for emergency services or nonemergency services as set forth in Virginia's Balance Billing Protection, you may be entitled to a refund of the excess amount that you paid to the provider.

If you are a Massachusetts resident, Massachusetts law addresses surprise billing in the following ways:

- Insurers are required to establish a toll-free telephone number and website that enables you to request and obtain the network status of a provider and estimated amount or charge for admission or service.
- Providers must tell you they are out-of-network prior to your appointment or admission.
- Out-of-network providers must provide an estimate of the amount that you will be charged for admission, a procedure, or service not covered through your health plan. In-network providers must provide this information upon request.
- Providers must inform you that a referred provider may be out-of-network and out-of-network rates may apply prior to any referral. Upon arranging or scheduling services with another provider, providers are required to verify and notify you whether the provider is out-of-network.
- An out-of-network provider who fails to provide you notice that they are out-of-network must only bill you for the applicable copayment, coinsurance or deductible that would be payable if you received the service from an in-network provider under the terms of your health benefit plan.

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 inadvance (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 anin-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 servicestoward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact CMS or one of the below state agencies.The federal CMS phone number for information and complaints is: 1-800-985-3059. The Florida Department of Health website for information and filing a complaint is: https://www.flhealthcomplaint.gov/. The Virginia State Corporation Commission Bureau of Insurance phone number and website for information and filing a complaint is: 1-877-310-6560 and https://scc.virginia.gov/pages/File-Complaint-Consumers. The Maryland Office of Attorney General Health Education and Advocacy Unit phone number and website for information and filing a complaint is: 1-877-261-8807 and https://www.marylandattorneygeneral.gov/Pages/CPD/HEAU/compOLBillEquipDispute.aspx. The Ohio Department of Insurance phone and website for information and filing a complaint is: 1-800-686-1526 and consumer.complaint@insurance.ohio.gov. The Office of the Alabama Attorney General phone number and website for information and filing a complaint is: 1-800-392-5658 and https://www.alabamaag.gov/ConsumerComplaint. The Washington State Office of the Insurance

Commissioner phone and website for information and filing a complaint is: 1-800-562-6900 and www.insurance.wa.gov. You may also file a complaint directly with the provider's professional licensing board or with the Massachusetts Department of Public Health at 617-624-6000.

Visit *www.cms.gov/nosurprises/consumers* for more information about your rights under federal law, *https://scc.virginia.gov/pages/Balance-Billing-Protection* for more information about your rights under Virginia law, https://www.mass.gov/news/pricing-transparency-provisions-of-an-act-promoting-a-resilient-health-care-system-that-puts-patients-first-patients-first for more information about your rights under Massachusetts law, and http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0600-0699/0627/Sections/0627.64194.html for more information about your rights under Florida law.