

Surprise Medical Bills

Your Rights and Protections

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, such as a copayment, coinsurance, 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.

“Out-of-network” describes providers and facilities that haven't signed a contract with your health plan. Out-of-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—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.

Under Federal Law, Members 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 balance billed for these post-stabilization services.

Air Ambulance

- If you receive transportation from an out-of-network air ambulance service and your plan covers in-network air ambulance services, you can only be billed for the cost sharing amount that would be applicable if the transport was provided by an in-network air ambulance service.

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 may be out-of-network. In these cases, the most those 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 protections 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 protections.

Under Texas Law, TX Members are Protected from Balance Billing for:

Out-of-network Emergency Care

- You receive emergency care services and/or treatment in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility.

Out-of-network Facility Based Providers

- You receive medical care services and/or treatment from an out-of-network doctor, while at an in-network hospital or health care facility.

Out-of-network Diagnostic Imaging Provider or Laboratory Service Providers

- You receive imaging or laboratory services from an out-of-network provider, which are in connection with medical care performed by an in-network doctor.

Out-of-network Emergency Medical Service Providers

- You receive emergency care services, treatment, or transport from an out-of-network EMS provider, except for air ambulance.

ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN UNLESS BALANCE BILLING FOR THOSE SERVICES IS PROHIBITED

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

Protections Also Apply:

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 emergency services without requiring you to get approval for services in advance (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 deductible and out-of-pocket limit.

If you Believe You've Been Wrongly Billed

You can contact the Employee Benefits Security Administration (EBSA), the No Surprise Help Desk (NSHD) at 1-800-985-3059 or cms.gov/nosurprises or your State Regulator, if your plan is fully insured, to ask whether the charges are allowed by law.

Visit <https://www.cms.gov/medical-bill-rights> for more information about your rights under federal law.

To learn more about your rights under state law

- Florida - [Division of Consumer Services](#) (1-877-693-5236) or [Office of Insurance](#) (1-850-413-3140)
- Georgia - [Division of Consumer Services](#) (1-800-656-2298)
- Texas - [Texas Department of Insurance](#) (1-800-252-3439)

