No Surprises Act

When you receive emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected under the law from surprise billing or balance billing.

What is Balance Billing or Surprise Billing?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs as determined by your health plan (copayment, coinsurance, and/or a deductible). If you see a provider or visit a health care facility that is out-of-network with your health plan, you may be responsible for other costs or the entire bill.

Out-of-network providers and facilities are those who haven't signed a contract with your health plan. These 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.

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 care at an in-network facility but are unexpectedly treated by an out-of-network provider.

Under the law, you are protected from balance billing for:

- **Emergency Services** – If you receive emergency care 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. This includes services you may receive after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these services.

- **Certain Services at an in-network hospital or ambulatory surgery center** – When you get care from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. Under the law, you are protected against balanced billing for the following services: emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. This means that the most these providers may bill you is your plan's in-network cost-sharing amount. Out-of-network providers for other services may be able to balance bill you for services at in-network facilities only if you give written consent and give up your protections. You are not required to give up your protections from balance billing.

You also are not required to get care out-of-network; you can choose a provider or facility in your health 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 (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 by out-of-network providers and without requiring you to get approval for services in advance (prior authorization).
- Base what you owe the provider or facility 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 have been incorrectly billed, please contact your health care provider.