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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, 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.

You 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 balanced billed for these post-stabilization services.

This notice was written by federal agencies. It is intended to provide you with a brief summary of some of the protections provided by the federal No Surprises Act. The laws in certain states may also provide protection from surprise billing. For instance, Ohioans who get health insurance through plans regulated by the Ohio Department of Insurance are also protected from receiving surprise medical bills under Ohio law. Ohio law provides the following protections when you receive unanticipated out-of-network care:

- *No balance billing for emergency services, including emergency services provided by an ambulance, even if they're provided out-of-network.*
- *Your cost-sharing amounts, such as copayments, coinsurance, and deductibles, are limited to the amount you would pay for in-network services.*

Health plans regulated by the state of Ohio should have the letters "ODI" clearly denoted on your insurance identification card.

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 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.

You're <u>never</u> 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.

In addition to the protections of the federal No Surprises Act, state law may provide certain protections that apply to your visit for emergency or non-emergency services. For instance, Ohioans who get health insurance through plans regulated by the Ohio Department of Insurance are also protected from receiving surprise medical bills under Ohio law. Ohio law provides the following protections when you receive unanticipated out-of-network care:

- *No balance billing by out-of-network providers at an in-network facility when you're unable to choose an in-network provider.*
- *Your cost-sharing amounts, such as copayments, coinsurance, and deductibles, are limited to the amount you would pay for in-network services.*

Health plans regulated by the state of Ohio should have the letters "ODI" clearly denoted on your insurance identification card.

<u>When balance billing isn't allowed, you also have the following protections:</u>

- 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 may contact the state insurance commissioner – see the table below for further details – or, regarding the federal No Surprises Act, you may contact the No Surprises Helpdesk at 1-800-985-3059. For more information about your rights under federal law, visit https://www.cms.gov/nosurprises/consumers.

State Entity	**Contact Information**
Ohio Department of Insurance	surprisebilling@insurance.ohio.gov 50 W. Town Street Suite 300, Columbus, OH 43215 1-800-686-1526
West Virginia Offices of the Insurance Commissioner	P.O. Box 50540, Charleston, WV 25305 1-888-879-9842

Please note that these rules do not apply to all types of health benefits. For instance, Medicare, Medicare Advantage, Medicaid, and Children's Health Insurance Program ("CHIP") are not subject to these rules. Similarly, excepted benefits such as stand-alone dental or vision plans are not subject to these rules. Ask your health insurance issuer or your Plan Administrator whether these rules apply to your benefits.