

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 facility, including a 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 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.

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, including a hospital or ambulatory surgery center, 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 see the information regarding Illinois law below.

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

When you get services from an in-network facility, including a 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 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.

Please see the information regarding Illinois law below.

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 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.

Illinois Law:

Illinois law generally contains balance billing protections similar to those under the No Surprises Act (as described in this Notice), for individuals with Illinois Department of Insurance-regulated plans (i.e., preferred provider organization ("PPO") plans and health maintenance organization ("HMO") plans). If receiving services in a hospital, note that you may receive separate bills for services provided by providers affiliated with the hospital, some of which may not be participating providers in the same insurance plans and networks as the hospital. As explained in this notice, you may have a greater financial responsibility for services provided by providers at the hospital who are not under contract with your insurance plan. If you are unsure whether you have one of these plans or if you have questions about coverage or benefit levels, call your insurance carrier.

If you think you've been wrongly billed, contact the HHS No Surprises Helpdesk at 1-800-985-3059, which is the entity responsible for enforcing the federal balance or surprise billing protection laws. Visit [cms.gov/nosurprises/consumers](https://www.cms.gov/nosurprises/consumers) for more information about your rights under federal law.

Illinois also has an independent dispute resolution process to resolve claims-related issues, including disputes between your provider or insurance plan pertaining to receipt of improper balance bills. If you are an Illinois Department of Insurance enrollee and you think you've been wrongly billed by your health insurer, you may submit an online complaint at www2.illinois.gov/sites/Insurance/Consumers/Pages/File-a-complaint.aspx or call (866) 445-5364. If you believe you received an improper balance bill from your health care provider, you may also file a complaint with the Illinois Attorney General's Health Care Bureau at illinoisattorneygeneral.gov/consumers/healthcare.html or call (877) 305-5145.