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.

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, 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 these post-stabilization services.

Under Illinois state law, if your health plan provides coverage for emergency services and you receive 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 balanced billed for these emergency services and your health plan must cover these services without requiring you to get approval in advance (prior authorization).

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 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.

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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.

Similarly, under Illinois state law, if you receive services from an out-of-network provider at an in-network hospital or ambulatory surgical center and an in-network provider is not available, the most the out-of-network provider may bill you is your plan's in-network cost sharing amount. These providers **can't** balance bill you. This applies to radiology, anesthesiology, pathology, emergency physician, or neonatology services.

Additionally, under the Illinois Fair Patient Billing Act, all Illinois hospitals are required (among other things) to notify patients of the availability of financial assistance, provide detailed billing information, and follow a specific protocol prior to submitting patients to collection actions. The Act has a specific provision concerning insured patients, who may have a difficult time paying their out-of-pocket share of a bill in one lump sum. According to the Act, a hospital may **not** refer a bill for collections without first offering an insured patient the opportunity to request a reasonable payment plan for the amount personally owed by the patient. A "reasonable payment plan," according to the Act, is one that takes into account the patient's available income and assets, the amount owed, and any prior payments the patient has made.

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 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.
- Generally, your health plan 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 in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact:

- The U.S. Centers for Medicare & Medicaid Services (CMS) at 1-800-633-4227 or No Surprises Help Desk (NSHD) at 1-800-985-3059. Visit www.cms.gov/nosurprises for more information about your rights under federal law.
- The Illinois Attorney General Health Care Bureau at 1-877-305-5145 (TTY 1-800-964-3013). Visit www.illinoisattorneygeneral.gov/consumers/healthcare.html for more information about your rights under Illinois law.