No Surprises Act 2022

Know 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 balanced billing.

What is "balanced billing" (sometimes called "surprised billing)? When you see a doctor or other health care provider, you may owe certain out of pocket costs, such as co-payment, coinsurance, and/or a deductible. You may have to pay the entire bill if you see a provider or visit a healthcare facility that is not in your health plan's network.

Out of network described providers or facilities that have not 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 "balanced billing". This amount is likely than out of network costs for the same service and might now count toward your annual out of pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot control who is involved in your care-like when you have an emergency or when you schedule a visit with an in-network facility, but you are unexpectedly treated by an out-of-network provider.

You are protected from balanced 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 out-of-network cost-sharing amount (such as copayments and coinsurance). You can't be billed for these emergency services. This includes services you may get after you are in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

-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 that providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistance surgeon, hospitalist, or intensivist services. These providers cannot bill you and may not ask you to give up your protection and not be balanced billed. If you get other services at these in-network facilities, out-of-network providers cannot balance the bill unless you give written consent and give up your protections.

You are never 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 plan's network.

When balanced billing is not allowed, you also have the following protections:
-You are only responsible for paying your share of the cost (such as a co-payment, co-insurance and deductibles that you would pay if the provider or the 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 the 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-pocket limits.

If you believe you have been wrongly billed, you may contact the No Surprise Billing Help Desk: 1-800-985-3059 for more information about your rights.