

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

WHEN YOU OBTAIN EMERGENCY CARE OR ARE 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 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 **cannot** be balance billed for these emergency services. This includes services you may receive 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.

See a summary of related state balance billing laws at: <https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections>.

CERTAIN SERVICES AT AN IN-NETWORK HOSPITAL OR AMBULATORY SURGICAL CENTER

When you obtain 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 **cannot** balance bill you and may **not** ask you to give up your protections not to be balance billed.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

If you obtain other services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. Also, you are not required to obtain care out-of-network. You can choose a provider or facility in your plan's network.

In certain states, you may also have related state protections:

Visit The Commonwealth Fund website for updated state balance-billing protections at <https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections>.

Applicable state balance billing laws or requirements for noted states are as follows:

IOWA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
 - To HMO and PPO enrollees
 - For emergency services provided by out-of-network professionals and facilities
 - Provided by all or most classes of health care professionals
- Protections do not apply to:
 - enrollees of self-funded plans
 - non-emergency services

When balance billing isn't allowed, you also have the following protections:

- 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:

Visit <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act> for more information about your rights under federal law.

Visit <https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections> for more information about your rights under your state laws.