The following information is being provided to you about the No Surprises Act, part of the Consolidated Appropriations Act of 2021. Services related to emergency medicine will not be subject to cost sharing exceeding in-network amounts, but be aware that there are some services performed by non-network providers at in-network facilities that can be subject to balance billing with prior written consent.  This makes this practice illegal beginning January 1, 2022.

If you encounter any wrongful balance billing issues after January 1, please contact your medical insurance provider. For Anthem Blue Cross HMO and PPO Members the Member Service Department phone number is 800-825-5541. For Kaiser Permanente Members the Customer Service phone number is 800-464-4000.

## 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.

#### Certain services at an in-network hospital or an in-network ambulatory surgical center

When you get services from an **in-network** hospital or **in-network** 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.

In the case of non-emergency services, the law lays out specific notice and consent requirements that, if met, permit balancing billing. This exception does not apply to the ancillary services, described above.

Providers who are eligible to request a consent waiver must include a written notice to the patient not later than 72 hours before the date on which the items or services are provided. The notice must include the following information:

* Notification that the provider or facility is out-of-network
* Clear statement that consent is optional and the patient can seek care from an in-network provider
* Good faith estimate of the amount the patient may be charged
* If the service is to be furnished by an out-of-network provider in an in-network facility, a list of in-network providers who are able to provide the service
* Information on whether prior authorization is needed.

Once the patient receives the notice, they have the option to consent. The notice must be signed by the patient where the patient acknowledges that they were provided with written notice and informed about the payment and how it may affect cost-sharing.

Out of Network Providers, when balanced billing is allowable:

Services from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes. If the services are not rendered at an in-network facility, is not an emergency care service, or fall under the aforementioned protections for the member, the provider may balance bill.

**You’re never 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.**

### 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**, you may contact your insurance carrier to assist in resolving the matter.

Visit <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act>

for more information about your rights under federal law.