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.

Participants, beneficiaries, enrollees, or covered individuals in group health plans or group health insurance coverage, including Federal Employees Health Benefits (FEHB) plans, please take note of your rights and protections against surprise medical bills.

What is "balance billing" (sometimes called "surprise billing"?

When you see a doctor or other health care provider, you may owe certain out-of-pockets costs, such as a copayment, coinsurance and/or a deductible. You may have other costs or have to pay the difference between the amount your health plan pays for the items and services and 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 facility 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 charges 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 towards 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 you will have to pay the provider or facility 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 balance billed for these post-stabilization services.

Ohio law protects patients covered by state-regulated insurance plans and insurance plans subject to the jurisdiction of the superintendent of insurance from balance-billing for covered emergency services provided by an out-of-network provider at an out-of-network emergency facility and at an in-network emergency facility. These protections require patients to pay only their in-network cost-sharing amounts. For more information, see Ohio Rev. Code §§ 3922.01, 3902.50, 3902.51.

If you believe you've been wrongly billed, you may contact the Ohio Department of Insurance at **800-686-1526**.

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 you will have to pay these providers 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.

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.

Ohio law protects patients covered by state-regulated insurance plans and insurance plans subject to the jurisdiction of the superintendent of insurance from balance-billing for covered services provided by an out-of-network provider at an in-network facility if a patient did not have the ability to request an in-network provider. These protections require patients to pay only their in-network cost-sharing amounts. For all other medical services provided to a covered patient by an out-of-network provider at an in-network facility, a patient cannot be balance-billed unless the patient is informed, provided with a good faith estimate of the cost of the healthcare services, and consents. For more information, see Ohio Rev. Code §§ 3922.01, 3902.50, 3902.51.

If you believe you've been wrongly billed, you may contact the Ohio Department of Insurance at **800-686-1526**.

When balance billing isn't allowed, you also have these 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 the Ohio Department of Insurance at **800-686-1526**.

Visit www.cms.gov/nosuprises/consumers for more information about your rights under federal law.