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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, 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 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 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 can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). For medical services provided on or after January 1, 2022, you **can't** be balance billed pursuant to the No Surprises Act 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.

The State of Texas has a similar law that applies to state regulated health insurance plans (including state employee and teacher retirement systems). Under that law (passed during 2019), balanced billing is banned in emergencies or when the patient otherwise did not have a choice of providers for medical services (such as an out-of-network physician treating a patient in an in-network facility) for medical services received on or after January 1, 2020. The Texas law does not apply to Medicare or self-funded plans.

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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 can 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.

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.

The Texas Department of Insurance ("TDI") provides a form for individuals who are considering waiving the protections provided by Texas balance billing laws. That form includes a way that patients can obtain a total estimate of what the patient would be responsible for paying if that patient agrees to pay the full billed charges for services and supplies from an out-of-network provider. A copy of that TDI form is available at FWBSI.com/forms.

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 deductible and out-of-pocket limit.

If you believe you've been wrongly billed, contact the federal no surprises help desk by calling 1-800-985-3059. The contact phone number for the TDI Insurance Consumer Protection hotline is 1-800-252-3439.

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.
Visit https://www.tdi.texas.gov/tips/texas-protects-consumers-from-surprise-medical-bills.html for more information about your rights under Texas state laws.