# No Surprises Act: Billing Disclosures

Effective January 1, 2022, the federal No Surprises Act protects patients from surprise bills for emergency services and certain non-emergency services provided by out-of-network providers at in-network facilities. If these protections apply, you only have to pay in-network cost-sharing amounts. Texas law also protects patients from surprise bills.

# Your Rights and Protections Against Surprise Medical Bills

State and Federal law protect you from "balance" or "surprise billing" when you receive emergency treatment or non-emergency treatment from an out-of-network provider at an in-network hospital or ambulatory surgical center.

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

When you see a health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, or a deductible. You may also have other costs or have to pay the full bill if you see a provider or visit a health care facility that isn't in your health plan's network.

Out-of-network means a provider or facility hasn't signed a contract with your health plan. Out-of-network providers may be allowed to bill you for the difference in your plan's benefits and the full cost of a service. This is balance billing. A balance bill is likely more than your in-network costs for a service and may not apply to your annual out-of-pocket limit.

A surprise bill 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 get emergency services from an out-of-network provider or facility, the provider or facility may not bill you more than your plan's in-network cost-sharing amount (such as copayments and coinsurance). They **can't** balance bill you 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.

If you are insured by a state-regulated health-maintenance organization (HMO), preferred-provider organization (PPO), exclusive-provider organization (EPO), or a group plan, Texas law also prohibits non-network providers from billing you for emergency services in an amount greater than your applicable copayment, coinsurance, or deductible.

**Certain services at an in-network hospital or ambulatory surgical center**
When you get services from an in-network hospital or ambulatory surgical center, some 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.

**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.**

For HMO, PPO, EPO, and group-plan insureds, Texas law bars out-of-network providers at in-network facilities from billing you for non-emergency services, including diagnostic-imaging and clinical-laboratory services, in an amount greater than your applicable copayment, coinsurance, or deductible unless you provide written consent. You may obtain a copy of Texas's standard written-consent form at: https://www.tdi.texas.gov/rules/2019/documents/20196181abr.pdf.

## 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:

- The No Surprises Help Desk operated by the U.S. Department of Health and Human Services (HHS) at 1-800-985-3059, or visit **https://www.cms.gov/nosurprises** for more information about your rights under federal law.
- The Texas Department of Insurance Consumer Help Line at 800-252-3439, or visit the Texas Department of Insurance's website at www.tdi.texas.gov/medical-billing/suprise-balance-billing.html.