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 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 from:

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 **cannot** 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 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 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.

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 are 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.

In addition to federal laws, many states have laws that protect individuals from balance billing. For example, in Indiana, an out-of-network provider that is providing non-emergency services at an in-network facility cannot bill more than your insurance plan's agreed upon rate of reimbursement unless the provider, at least five days before the scheduled services, has given you a statement that explains there is a plan to charge you more than your insurance plan's in-network reimbursement amount and

provides an estimate of those charges. The law states that you would have to sign the statement consenting to the additional charges.

Balance Billing protections do not apply in all situations; for example, ground ambulance services or services provided under vision or dental plans may not qualify.

When balance billing is not allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copays, 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:

If you have a question, complaint, or dispute regarding insurance you get through a **"self-insured"** employer, contact IU Human Resources at **askhr@iu.edu** or 812-856-1234, or go to:

Contact info for HHS:

U.S. Department of Health & Human Services

200 Independence Avenue, S.W.
Washington, D.C. 20201

https://www.cms.gov/files/document/nsa-helpdesk.pdf

No Surprises Help Desk: 1-800-985-3059

https://www.cms.gov/medical-bill-rights/help/submit-a-complaint

Contact info for IDOI:

Indiana Department of Insurance
Consumer Service Department
311 West Washington Street, Suite 300
Indianapolis IN 46204-2787

https://www.in.gov/idoi/consumer-services/complaints/