# 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. Illinois law also protects patients from surprise bills.

# Your Rights & 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 pay the whole 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 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.

Illinois law protects you from balance billing (1) when you receive covered health care services at an in-network hospital or ambulatory surgical center, and (a) in-network services are unavailable and are provided by an out-of-network provider, (b) you did not willfully choose the out-of-network provider, and (c) you agreed in writing to assign your benefits to the out-of-network provider; and (2) when you receive emergency services under a health care plan or network plan, regardless of whether they are provided by a plan or non-plan provider. Despite these protections, you may still be billed for in-network cost-sharing amounts. These protections apply to all individual or group accident and health insurance policies with network plans in Illinois.

**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 to be balanced 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 protection 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.**

Illinois law also protects you from balance billing if your insurer offers services through a network plan, and you make a good faith effort to utilize a preferred provider, similar to an in-network provider, but the insurer does not have an appropriate preferred provider available to provide the covered health care services. In such a case, you will receive the covered service at no greater cost than if a preferred provider provided the service to you. This protection does not apply if you willfully choose a non-preferred provider (similar to an out-of-network provider) for your covered healthcare services or are enrolled in a health maintenance organization.

## 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 you would pay if the provider or facility were 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 or prior authorization for services in advance.
  - 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 US 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 Illinois Department of Insurance at 312-814-2420 or 217-782-4515.