Your Rights and Protections Against Surprise Medical Bills

The No Surprise Act prevents healthcare consumers from "surprise" medical billing and removes them from billing disputes between insurance companies and health care providers.

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

The term "surprise medical bill" refers to unexpected or higher-than-expected charges to the consumer after they receive care from an out-of-network provider. This often happens when consumers are treated at an in-network facility but see an out-of-network provider, or receive emergency care and have no chance to choose their provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service. "Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services.

Out-of-network providers may be allowed 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 plan's deductible or annual out-of-pocket limit.

To protect consumers, the No Surprise Act:

- Bans surprise billing following emergency care, non-emergency care from out-of-network providers at in-network facilities (including ancillary care), and out-of-network air ambulance services. In these situations, the ruling mandates that consumers cannot be billed above what the cost would have been from an in-network provider. The rule also affirms that emergency services don't require prior authorization, regardless of the provider's network status.

- Requires providers and care facilities to provide good-faith cost estimates up front to patients who are uninsured or self-pay. Providers must make these cost estimates available orally and in writing when consumers schedule a service, or beforehand upon request. Estimates must cover every item or service the patient might be billed for in conjunction with the service they're scheduling.

- Establishes an arbitration process for billing disputes if consumers are billed more than the good-faith estimate, as long as the difference is at least $400. Consumers will also have expanded avenues to dispute an insurance company's rejection of a claim.

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.

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 HHS Department of Labor and the Office of Personnel Management at 1-800-985-3059.

To file a complaint, visit https://oci.wi.gov/Pages/Consumers/Types-of-Complaints.aspx.

For more information about your rights under federal law, visit www.cms.gov/nosurprises/consumers.