U.S. PIRG

Surprise Billing Patient Protections

What is a surprise medical bill?

One in five insured Americans who have surgery or visit an emergency room receive a surprise medical bill. Surprise medical bills occur when patients get "balance billed" for the difference between what their insurer covers and what an out-of-network provider charges. Often, patients don't know that the provider who treated them was out-of-network until they're at home, recovering, and they receive a medical bill for hundreds or even thousands of dollars that their insurance company isn't obligated to pay.

As of Jan. 1, 2022, a new law called the No Surprises Act protects insured Americans from most surprise medical bills. The following tips will help you know and use your new rights.

New protections from surprise medical bills

Patients should not receive a surprise medical bill from an out-of-network provider in the following situations:

1. When you receive emergency care in an emergency room
2. When you receive any care at an in-network health care facility
3. When you are transported by an air ambulance (airplane or helicopter).

Patients admitted to an out-of-network hospital for emergency services cannot be charged out-of-network rates for "post-stabilization" care unless ***all*** of the following conditions are met:

1. You can travel safely without medical transportation to an in-network facility
2. That in-network facility is willing to accept your transfer
3. The transfer will not cause you unreasonable burden
4. You provide written consent to the transfer.

TIP:
The No Surprises Act protections do ***not*** apply to ground ambulance transportation. You still may receive an out-of-network balance bill for ambulance services. In 10 states -- CO, DE, FL, IL, ME, MD, NY, OH, VT, WV -- some people have limited protections against surprise ambulance bills. If you live in one of these states, call your insurance department to find out if the protections apply to you.

Providers are not allowed to bill you for their full out-of-network charges in any of these situations. Instead, they must send their claim directly to your health plan, find out what your cost-sharing amounts (co-pay, co-insurance and deductible) are for an in-network service and then bill you no more than that.

> **TIP**:
> Your health plan must give you a statement (called an explanation of benefits or EOB) showing the in-network cost-sharing amount you owe for a surprise bill. Before paying the provider, compare the bill to your EOB to be sure you have not been overcharged.

Location of treatment matters

These protections only apply when you are treated in certain types of health care facilities.

For emergency care:
All hospital emergency rooms, freestanding emergency departments and urgent care centers that are licensed to provide emergency care, whether in or out of your plan's network.

For non-emergency care:
Hospitals, hospital outpatient departments and ambulatory surgery centers that participate in your plan's network.

These protections ***do not apply*** when you are in other types of health care facilities -- such as birthing centers, clinics, hospice, addiction treatment facilities, nursing homes or urgent care centers -- that are not licensed to provide emergency care. In these settings, before treatment, always ask first if this health care facility and its providers are part of your health plan's covered network.

> **TIP:**
> Ask: "Are you part of my plan's network?"
> Do not ask: "Do you take my insurance?"
> Sometimes a provider says it will "take" your insurance but it is not in your insurance plan's network. What the provider means is that it will send the bill to your insurance plan for you but will still charge you an out-of-network rate.

Think carefully before signing the 'Surprise Billing Protection Form'

In non-emergency situations, when you are scheduling treatment in advance, some out-of-network doctors may ask you to sign the Surprise Billing Protection Form. By signing that document, you agree to pay their out-of-network charges. The Surprise Billing Protection Form must include a good faith estimate with itemized costs and in most cases, it must be provided at least three days before treatment. The Form should also list in-network doctors who are available to provide that same care.

Think carefully before you sign the Surprise Billing Protection Form because if you sign it,

1. You will lose your protections from surprise medical bills
2. You are agreeing to pay out-of-network charges from that provider. These charges will be higher than if you use a provider in your health plan's network.

TIPS:
Do not consider signing the Surprise Billing Protection Form until you have read the waiver, received your estimate of charges and have decided you will pay the out-of-network charges listed in the form. (These amounts are **not** applied to your deductible.)

If you do not want to owe out-of-network charges, review the Form for the names of providers in your health plan network and choose one of them instead. Do not sign the Form.

Emergency physicians or facilities, assistant surgeons, anesthesiologists, radiologists, hospitalists, intensivists and some other providers are **not** allowed to ask you to sign this form. Do not sign the Form if any of these providers ask you to, and report this violation to **https://www.cms.gov/nosurprises or call 1-800-985-3059.**

File a complaint or dispute a bill

If you think you have received a surprise medical bill, you should contact both the provider and your insurer immediately. If they continue to ask for payment, you should file a complaint at https://www.cms.gov/nosurprises or call 1-800-985-3059. You must file your complaint within 120 days of the date of your first bill.

If you are uninsured or decided not to use your insurance, you have the right to an estimate of charges in advance of treatment. If your final bill is more than $400 higher than the estimate, you can dispute the bill by filing a complaint at https://www.cms.gov/nosurprises or call 1-800-985-3059. You must file your complaint via this provider-patient dispute system within 120 days of the date of your first bill. The provider cannot pursue collections or impose late charges until the complaint is resolved.

If your insurer has denied a health claim that you think should be covered, you can dispute claim denials. First, appeal the denial "internally" with your plan. You must file your appeal within 180 days of the date of your explanation of benefits that shows your claim was denied. If the insurance company doesn't change its decision, you can use an "external review process." Your explanation of benefits will explain how and should include contact information for a Consumer Assistance Program that can help you. You can also call 1-800-985-3059 for assistance.

For any questions about your surprise billing protections, go to https://www.cms.gov/nosurprises or call 1-800-985-3059.