No Surprises Act

The U.S. Congress enacted the No Surprises Act (NSA), which contains many provisions to help protect consumers from surprise bills beginning January 1, 2022. The provisions in the NSA create requirements such as cost-sharing rules, prohibitions on balance billing for certain services, notice and consent requirements, and requirements related to disclosures about balance billing protections. The requirements in the NSA apply to healthcare providers and facilities and providers of air ambulance services. These requirements apply to items and services provided to individuals enrolled in group health plans or group or individual health insurance coverage, including Federal Employee Health Benefit plans. The NSA also requires providers and facilities to give good faith estimates to patients who do not have or are not using insurance, and the patient-provider dispute resolution process may apply.

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 balance billing. In these cases, you should not be charged more than your plan’s copayments, coinsurance and/or deductible.

What is “balance billing” (also called “surprise billing”)?

When you see a doctor or other healthcare provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or a deductible. You may have additional costs or may be asked to pay the entire bill if you see a provider or visit a healthcare facility that is not in your health plan's network.

"Out-of-network" means providers and facilities that have not 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 often more than in-network costs for the same services provided and may not count toward your plan's deductible or annual out-of-pocket limit.

“Surprise billing" is an unexpected balance bill. This can happen when you cannot 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 have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance and deductibles). You cannot be balance billed for these emergency services. This includes services you may get after you are in stable condition unless you give written consent and give up your protections.

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 can 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 types of services at these in-network facilities, out-of-network providers cannot 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 are not required to get out-of-network care.

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "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 in-network deductible and out-of-pocket limit.
- **If you believe you have been wrongly billed:**
- Visit Centers for Medicare & Medicaid Services (CMS) at cms.gov/medical-bill-rights for more information about your rights under federal law. You may also contact the No Surprises Help Desk by calling **1-800-985-3059.**

You have the right to receive a "good faith estimate" explaining how much your healthcare will cost.

Under the law, healthcare providers need to give patients who do not have certain types of healthcare coverage or who are not using certain types of healthcare coverage an estimate of their bill for healthcare items and services before those items or services are provided.

- You have the right to receive a good faith estimate for the total expected cost of any healthcare items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

- If you schedule a healthcare item or service at least 3 business days in advance, make sure your healthcare provider or facility gives you a good faith estimate in writing within 1 business day after scheduling. If you schedule a healthcare item or service at least 10 business days in advance, make sure your healthcare provider or facility gives you a good faith estimate in writing within 3 business days after scheduling. You can also ask any healthcare provider or facility for a good faith estimate before you schedule an item or service. If you do, make sure the healthcare provider or facility gives you a good faith estimate in writing within 3 business days after you ask.
- If you receive a bill that is at least $400 more for any provider or facility than your good faith estimate from that provider or facility, you can dispute the bill.

For questions or more information about your right to a good faith estimate, visit cms.gov/medical-bill-rights,
email FederalPPDRQuestions@cms.hhs.gov or call **1-800-985-3059**.