Your Rights and Protections against Surprise Medical Bills

When you get emergency care or get 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 for:

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 **can't** 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.

Surprise bills, sometimes called balance bills, happen when a provider charges more for treatment than your health benefit plan pays – and you get the bill for the difference. You may get a balance bill when you get care from a doctor, hospital, or other health care provider outside your health plan's network. Sometimes, you may choose to seek care out of your plan's network and know you will receive a bill. But often, a balance bill can be a surprise. This often happens in three situations:

- While you are getting treatment at an in-network hospital or facility, you also get care from another provider who does not have a network contract with Blue Cross and Blue Shield of Texas (BCBSTX).

- You visit an in-network doctor, but that doctor sends your lab work or imaging to an out-of-network provider for testing or review.
- You get emergency treatment at an out-of-network hospital or emergency facility.

The Surprise Billing law bans providers from sending balance bills to you in those cases. Instead, providers can work directly with your health plans to agree on payment for those bills.

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 **can't** 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'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.

The law protects you from being surprise billed for more than your deductible, copays or coinsurance if:

- You are treated by an out-of-network provider in a network facility.
- You get emergency services and supplies.
- Your in-network doctor uses an out-of-network diagnostic imaging provider or lab.

For example, if your in-network doctor takes a blood sample in his office and sends it to an out-of-network lab, you are protected from balance billing unless you signed a balance billing waiver in advance. However, you are not protected if your in-network doctor orders an X-ray of your foot and you choose to go to an out-of-network imaging center. The difference is that, in this case, you had an opportunity to choose an in-network imaging center.

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 Texas Department of Insurance at **1-800-252-3439**.

Visit www.tdi.texas.gov for more information about your rights under federal law.