of Tennessee

Your Rights and Protections Against Surprise Medical Bills

The No Surprises Act, a new federal law, protects you from getting surprise medical bills when you get out-of-network care:

- During a medical emergency
- At an in-network facility (a hospital or ambulatory surgical center)
- Via air ambulance transports from the scene of an accident or when prior approval is received

What is "balance billing" or "surprise billing?"

When you see a health care provider, you may owe a share of the cost. This is for things like your deductible, copays and/or coinsurance. Your share of the costs is often much higher when you see a provider or go to a facility that isn't in your health plan's network.

Out-of-network providers and facilities haven't signed a contract with your health plan. So, these providers can send you a bill for the difference between what your health plan paid and the full amount the provider charged for the service. This is called balance billing. This amount is likely more than in-network costs for the same service and may not count toward your annual out-of-pocket maximum.

"Surprise billing" is a balance bill you don't expect. A surprise bill can happen when you can't control who's involved in your care, like:

- When you have an emergency
- When you schedule services at an in-network facility but are unexpectedly treated by an out-of-network provider.

You're protected from balance billing for:

Emergency services

You're protected if you have an emergency medical condition and get emergency services from an out-of-network provider. In these cases, the most the provider may bill you is your plan's in-network cost-sharing amount (this includes your in-network deductible, copay and/or coinsurance). You can't be balance billed for 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 services.

Certain services at an in-network hospital or outpatient surgical center

When you get services from an in-network hospital or outpatient 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 *aren't allowed* to ask you to give up your protections against balance billing.

If you get other services at these in-network facilities, out-of-network providers *may* balance bill you if 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.

When balance billing isn't allowed, you also have the following protections:

- You're only responsible for paying your share of the cost (like the copays, coinsurance, and deductibles that you'd pay if the provider or facility was in network). Your health plan will pay the 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 from out-of-network providers.
  - Base your share of the cost on what you would pay an in-network provider and show that amount in your claim summary (also known as an explanation of benefits).
  - Count your share of the costs for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you can call us using the number on the back of your ID card. You may also contact the federal No Surprises Help Desk (NSHD) by calling **1-800-985-3059**. Visit **cms.gov/nosurprises** for more information about your rights under federal law.

21COM1333500 (11/21)