

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 balance billed for these post-stabilization services.

Florida

Comprehensive Balance Billing Protections

PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

- To HMO and PPO enrollees
- For (1) emergency services by out-of-network professionals and facilities and (2) non-emergency services provided by out-of-network professionals at in-network facilities
- Provided by all or most classes of health care professionals
- For PPOs, state payment standard applies to (1) emergency services and (2) non-emergency services provided by out-of-network professionals at in-network facilities*
- For HMOs, state payment standard only applies to emergency services* but the state also has a claim dispute resolution program in place
- Protections do not apply to:
 - ground ambulance services for PPO enrollees
 - PPO enrollees who consent to non-emergency out-of-network services**
 - enrollees of self-funded plans

Notes:

* Where a payment standard applies, the insurer must reimburse the lesser of: (1) the provider's billed charges; (2) the usual and customary provider charges for similar services in the community where services were provided; or (3) the charge mutually agreed to by the insurer and provider within 60 days of claim submittal. For PPOs, any dispute with respect to reimbursement according to the payment standard as described above must be resolved either through the courts or through a voluntary dispute resolution process.

** Protections do not apply to non-emergency services when enrollee has the "ability and opportunity to choose" a network provider who is available to treat.

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.

[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 No Surprises Help Desk at 1-800-985-3059.

Visit <https://www.cms.gov/nosurprises/consumers> for more information about your rights under federal law.