

Effective January 1, 2022, the No Surprises Act, which Congress passed as part of the Consolidated Appropriations Act of 2021, is designed to protect patients from surprise bills for emergency services at out-of-network facilities or for out-of-network providers at in-network facilities, holding them liable only for in-network cost-sharing amounts. The No Surprises Act also enables uninsured patients to receive a good faith estimate of the cost of care.

Patient Rights and Protection against Surprise Medical Bills

When you receive emergency care or receive treatment by an out-of-network (OON) 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 be responsible for 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 do not have 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 deductible and 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 are in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

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

When you receive services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most a provider 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 receive other 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'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 Illinois Surprise Billing Law, PA096-1523 provides that the payment rate shall be at the agreed rate for covered items and services provided by a participating provider and at the usual and customary rate for covered items and services provided by a nonparticipating provider. Illinois General Assembly - Full Text of Public Act 096-1523 (ilga.gov)

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 think you've been wrongly billed, you may contact CMS at [800.985.3059](tel:800.985.3059).

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

Visit <https://www2.illinois.gov/sites/Insurance/Consumers/Pages/File-a-complaint.aspx> for more information about your rights with the Illinois Department of Insurance.

Good faith estimate for patients who don't have insurance or who are not using insurance

Under the law, healthcare providers need to give **patients who don't have insurance or who are not using insurance** a good faith estimate of the bill for medical items and services.

- You have the right to receive a good faith estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment and hospital fees.
- Make sure your healthcare provider gives you a good faith estimate in writing at least one business day before your medical service or item. You can also ask your healthcare provider, and any other provider you choose, for a good faith estimate before you schedule an item or service.
- If you receive a bill that is at least \$400 more than your good faith estimate, you can dispute the bill.
- Make sure to save a copy or picture of your good faith estimate.