# Your Rights and Protections Against Surprise Medical Bills

*When you receive 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 healthcare provider, you may owe certain out-of-pocket costs, such as copayment, coinsurance, and/or deductible. You may have other costs or have to pay the entire bill if you see/visit a provider/healthcare 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 (i.e. when you have an emergency or if 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 the following:

### 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, coinsurance). 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 not be balance billed for these post-stabilization services. The state of Georgia and the federal government both have laws to protect you from balance billing, although they are slightly different. State rules only apply to self-insured employer health plans and government plans. Federal rules may also apply to commercial health insurance in situations where you received health care services in another state, your health insurance is regulated by a state other than Georgia, or the health care service you received is not regulated by the state law. Most of the difference between the state and federal laws are in the way that the rules affect providers and health insurers. However, the grievance processes are different, as indicated on the government websites listed below.

### Certain Services at an In-Network Hospital, Ambulatory Surgical Center, or Other Facility

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, assistance surgeon, hospitalist, or intensivist services. These providers CANNOT balance bill you and may NOT ask you to give up your protections not to be balanced billed.

Under Georgia laws, this also applies to imaging centers, birthing centers, and similar facilities. If you get other services at these in-network facilities, out-of-network providers CANNOT balance bill you, unless you give up your protections through written consent.

You are NEVER required to give up your protections from balance billing. You are also not required to get care out-of-network. You can choose a provider or facility in your plan's network.

The best way to find an in-network provider is to use the online provider directory on your health plan's website.

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

1. You are only responsible for paying your share of the cost (i.e. copayments, coinsurance, deductibles) that you would pay if the provider or facility is in-network. Your health plan will pay out-of-network providers and facilities directly

2. Your health plan must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization). Under Georgia law, your health plan CANNOT later deny such services because they are not considered to be medically necessary.
- 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.

If you believe you have been wrongly billed, first contact your provider and/or health plan for an explanation. If they are unable to resolve your concerns, you can contact the Georgia Office of the Commissioner of Insurance and Fire Safety online at **https://oci.georgia.gov** or by phone at **(404) 656-2070.**

Visit https://www.cms.gov/nosurprises for more information regarding your rights under federal law.

Visit https://oci.georgia.gov/how-do-i-file-complaint for more information about y