

# Your Rights and Protections Against Surprise Medical Bills

## What is “balance billing” (sometimes called “surprise billing”)?

If you see a healthcare provider or healthcare facility that isn’t in your health plan’s network of providers and facilities (or “out-of-network”), they may 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 may be more than what you would have paid for the same service if you had seen an in-network provider or healthcare facility, and it may not count toward your annual out-of-pocket limit.

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 may receive an unexpected balance bill. This is called “surprise billing.”

## You are protected from balance billing for:

**Emergency services:** You can’t be balance billed for emergency services from an out-of-network provider or facility to treat an emergency medical condition. The most the provider or facility may bill you is the cost-sharing amount (such as copayments and coinsurance) that you would have paid at an in-network provider or facility. This includes services you may get after you’re in a stable condition, unless you give written consent to be balance-billed and give up your protections.

**Certain non-emergency services at an in-network hospital or ambulatory surgical center provided by out-of-network provider:** For many non-emergency services at in-network hospitals or ambulatory surgical centers, out-of-network providers can’t balance bill you, unless you give written consent and give up your protections. In the case of emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, these providers can never balance bill you, and may not ask you to consent to give up your protections not to be balance billed. The most those providers may bill you is your plan’s in-network cost-sharing amount.

## Illinois Law

In addition to protections under federal law, Illinois law may also protect you from balance billing. If you have a health plan overseen by the State of Illinois and you receive anesthesiology, emergency, laboratory, pathology, or radiology services provided by an out-of-network provider at an in-network hospital or ambulatory surgical center, those providers can’t balance bill you under Illinois law.

**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:**

**Attune Menopause Care PLLC**

1-872-253-4891

office@attunemenopausecare.com

or

**Federal No Surprises Helpdesk**

1-800-985-3059

or

**Illinois Department of Insurance**

**Office of Consumer Health**

**Insurance**

320 West Washington Street

Springfield, IL 62767

Toll-free: 877-527-9431

TDD: 866-323-5321

Fax: 217-558-2083

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