

# Your Rights and Protections against Surprise Medical Bills under the No Surprises Act as of 1/1/2022



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. This protection will begin on or after 1/1/2022, depending on when your health plan coverage year begins.

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

When you see a doctor or other health care provider in the United States, 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” providers are doctors, facilities, and other health care providers that haven't signed a contract with your health plan. Out-of-network providers may be able to bill you for the difference between what your plan agreed to pay for a service and what they want to charge. This is called “**balance billing**.” This bill may be more expensive than an in-network provider 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. This can also happen when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. For example, you may go to an in-network hospital but then an out-of-network provider treats you. This could happen when you need anesthesia during a surgery. The surgeon may be in-network, but the anesthesiologist may be out-of-network. Both providers can bill you for the care they give.

## **You are protected from balance billing for:**

### **Emergency services**

If you have an emergency and you get care from an out-of-network provider or facility in the United States, the most they can bill you is your plan's in-network cost-sharing amount (such as a copay and coinsurance). This means you'll pay what you would have if you got care from an in-network provider. 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.

### **Certain non-emergency services at an in-network hospital or ambulatory surgical center**

You're also protected when you get services from an in-network hospital or ambulatory surgical center in the United States. Certain providers there may be out-of-network. You may not know which providers are in- or out-of-network. It's always good to ask whether a provider participates in your health plan's network if you can. If the provider is out-of-network, the most they may bill you is your plan's in-network cost-sharing amount (such as a copay or coinsurance). This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, an assistant surgeon, hospitalist, or intensivist services. **These providers can't balance bill you and may not ask you to give up your protections against being 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 have the right to choose a provider or facility in your plan's network.**

A state balance billing law may also apply to your health plan. For more information about these protections, please visit the section on [FEDERAL and STATE-SPECIFIC NOTICES AND DISCLOSURES](#) on Cigna.com.

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

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 (EOB).
- 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**

Please call Cigna if you get a balance bill. Use the phone number on your ID card. You can also contact the No Surprises Help Desk at 1-800-985-3059 or **<http://www.cms.gov/nosurprises>** for more information about your rights under federal law.

Cigna Global Health Benefits® customers may get this information by contacting Cigna using the number on their ID card or the *Contact Us* section on [Cigna Envoy®](#).

If you provided written consent to be financially responsible for your out-of-network services and have given up the protections described above, you might receive a bill from your provider or facility and/or an additional benefits explanation from Cigna addressing the amounts owed. Please contact Cigna if you receive a balance bill or if you have any questions.