

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network facility, including a hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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, like a copayment, coinsurance, or deductible. You may have additional 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" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays 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 plan's deductible or 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're 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, including a hospital or ambulatory surgery center, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). 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.

Please see below for information regarding Florida law.

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

When you get services from an in-network facility, including a hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can 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 types of 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 out-of-network care. You can choose a provider or facility in your plan's network.

Please see below for information regarding Florida law.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - Cover emergency services without requiring you to get approval for services in advance (also known as "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 in-network deductible and out-of-pocket limit.

Florida Law

Florida law generally contains balance billing protections similar to those under the No Surprises Act (as described in this Notice), except that if you have a certain type of health plan (i.e., fully funded commercial plans, such as preferred provider ("PPO") or exclusive provider plans ("EPO")), your provider cannot bill you more than your in-network, cost-sharing amount even if you provide consent. If you have one of these plans, Florida also extends balance billing protections to covered emergency and non-emergency services provided at an urgent care center. If you are unsure whether you have one of these plans, please review your insurance card, call your insurance carrier or contact AdventHealth patient financial services at 1-800-952-5462.

If you think you've been wrongly billed, contact the HHS No Surprises Helpdesk at 1-800-985-3059, which is the entity responsible for enforcing the federal balance or surprise billing protection laws. Visit cms.gov/nosurprises/consumers for more information about your rights under federal law.

Florida also has an independent dispute resolution process to resolve claims-related issues, including disputes with your provider or insurance plan pertaining to receipt of improper balance bills. If you have received an improper balance bill from your provider, you may file a complaint with the Florida Department of Agriculture and Consumer Services by visiting fdacs.gov/#. If you have received an improper balance bill from your insurer, you may file a complaint with the Florida Office of Insurance Regulation, Department of Financial Services, at myfloridacfo.com/division/consumers/.