**YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS**

**(OMB Control Number: 0938-1401)**

The purpose of this document is to let you know about your protections under federal and state law from unexpected medical bills.

**IMPORTANT**: **You can choose to get care from a provider or facility in your health plan’s network, which may cost you less than if you get care from a provider or facility that is out-of-network. You should never be required to sign a form giving up your rights and protections against surprise billing or balance billing.**

If you’d like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You are getting this notice to inform you of your rights if your provider or facility **isn’t** in your health plan’s network, which means the provider or facility doesn’t have an agreement with your plan.

\*If your provider **is** in your health plan’s network, this form does not apply to you, but this information is important for you to understand.

**Balance 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 have to pay the entire bill to see a provider or visit a health care facility that isn’t in your health plan’s network. 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:** “Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care, such as if 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 and surprise 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 or coinsurance). You cannot 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 services at an in-network hospital or ambulatory surgical center:** When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. The most these providers 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 cannot balance-bill you and may not ask you to give up your protections not to be balance-billed.

If you get 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 under the law.

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

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

As of January 1, 2020, Colorado law prohibits out-of-network providers from sending balance bills to consumers if the provider provides emergency services or covered nonemergency services to a covered person at an in-network facility (C.R.S. 12-30-113)

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

1. You are only responsible for paying your share of the cost (copayments, coinsurance, and/or deductibles you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
2. Your health plan generally must:

a. Cover emergency services without requiring you to get approval for services in advance,

b. Cover emergency services by out-of-network providers,

c. Base what you owe the provider or facility on what it would pay an in-network provider or facility and show that amount in your explanation of benefits,

d. 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 have been wrongly billed, you may contact:**

Colorado Department of Regulatory Agencies, Division of Insurance

<https://doi.colorado.gov/for-consumers/file-a-complaint>

Department of Health and Human Services - No Surprises Act

<https://www.cms.gov/nosurprises/consumers>

For more information about your rights under federal law, visit <https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf>

For more information about your rights under Colorado state law, visit <https://doi.colorado.cov/insurance-products/health-insurance/health-insurance-initiatives/out-of-network-health-care>