



CLAIM DETAIL (1 OF 1)

PATIENT: John Smith

PROVIDER: EMERGENCY INC

CLAIM # 12985036H9X0X

SERVICE DATES: 06/18/2022 - 06/18/2022

SAMPLE

DATE PROCESSED: 10/25/2022

SUBSCRIBER INFORMATION

GROUP NAME

Member ID#: XXXXXXXXX777V Group #: 000012345

Customer Advocates are here to help! <Customer Service Phone>

Amount Billed	\$1,166.34
Discounts and Reductions	- \$952.99
Health Plan Responsibility	- \$141.91
You may owe your health care provider for these services	\$71.44

		YOUR BENEFITS APPLIED				YOUR RESPONSIBILITY				
Service Description	Qualifying Payment Amount	Amount Billed	Discounts and Reductions	Amount Covered (Allowed)	Health Plan Responsibility	Deductible Amount	Copay Amount	Coinsurance	Amount Not Covered	Your Total Costs
Emergency Med Visit	357.18	1,166.34	(1) 952.99	213.35	141.91			71.44		71.44
CLAIM TOTALS	\$357.18	\$1,166.34	\$952.99	\$213.35	\$141.91	\$0.00	\$0.00	\$71.44	\$0.00	\$71.44

Total covered benefits approved for this claim: \$141.91 to EMERGENCY INC on 10/25/2022.

Notes about amounts under “YOUR BENEFITS APPLIED” and “YOUR RESPONSIBILITY”

- (1) This service is subject to the No Surprises Act, so you should not be billed for amounts over your cost-share for this service. Your cost-share is your deductible, copay, and/or any coinsurance you may owe. Your cost share is not based on the amount covered (allowed). By law, it is based on the lesser of the billed amount or the Qualifying Payment Amount (QPA). The QPA is based on amounts participating providers have agreed to accept for similar services in the area. The amount you owe may be different than shown on this notice, if before you got services you agreed in writing to allow the provider to bill you for amounts above your cost-share. If you have questions about a provider bill, call the number on your ID card.

For your up-to-date Medical Spending summary, visit Blue Access for MembersSM on our website, the BCBSIL Mobile App or call the phone number on the back of your ID card.

John Smith - Benefit Period: 01-01-22 Through 12-31-22 To date this patient has met \$2,500.00 of her/his \$2,500.00 Health Care Plan Deductible. To date this patient has met \$550.70 of her/his \$5,000.00 Out-of-pocket Expense.

Benefit Period: 01-01-22 Through 12-31-22 To date \$2,809.25 of your family Health Care Plan Deductible has been met. To date \$4,019.25 of the Family \$10,000.00 Out-of-pocket Expense has been met.

Your Rights and Protections Against Surprise Medical Bills

When you get 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 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 if you see a provider or visit a health care 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—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 are 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, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). 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 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. 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, 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 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 can choose a provider or facility in your plan's network.

Surprise Billing in Illinois

Illinois state law (Illinois Public Act 096-1523) protects you from “balance” or “surprise” bills when you receive care at an in-network facility or ambulatory surgery center from out-of-network providers who provide radiology, anesthesiology, pathology, neonatology, or emergency physician services at that in-network facility.

In these situations, you cannot be charged greater out-of-pocket expenses than you would have been for covered, in-network physician or provider services. The out-of-network provider should not send you a bill.

Exceptions to Illinois Surprise Billing Protections

You could, however, still be required to pay an out-of-network bill in certain situations. Illinois' surprise billing protections only apply to insurance plans regulated by the state of Illinois. Therefore, if your insurance plan is not regulated by the state, you may still be billed for these out-of-network charges. Further, these protections only apply to certain out-of-network providers who are based in an in-network facility; if the facility where you receive these services itself is out-of-network, you can also receive an out-of-network bill. Similarly, these protections do not apply if you purposely choose a provider not within your insurance 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:

The Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767
877-527-9431

Visit <https://www.cms.gov/nosurprises/consumer-protections> for more information about your rights under federal law.

Visit bcbsil.com for more information about your rights under Illinois state law.