No Surprises: Understand your rights against surprise medical bills

The No Surprises Act protects people covered under group and individual health plans from receiving surprise medical bills when they receive most emergency services, non-emergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service providers. It also establishes an independent dispute resolution process for payment disputes between plans and providers, and provides new dispute resolution opportunities for uninsured and self-pay individuals when they receive a medical bill that is substantially greater than the good faith estimate they get from the provider.

Starting in 2022, there are new protections that prevent surprise medical bills. If you have private health insurance, these new protections ban the most common types of surprise bills. If you're uninsured or you decide not to use your health insurance for a service, under these protections, you can often get a good faith estimate of the cost of your care up front, before your visit. If you disagree with your bill, you may be able to dispute the charges. Here's what you need to know about your new rights.

What are surprise medical bills?

- Before the No Surprises Act, if you had health insurance and received care from an out-of-network provider or an out-of-network facility, even unknowingly, your health plan may not have covered the entire out-of-network cost. This could have left you with higher costs than if you got care from an in-network provider or facility. In addition to any out-of-network cost sharing you might have owed, the out-of-network provider or facility could bill you for the difference between the billed charge and the amount your health plan paid, unless banned by state law. This is called "balance billing." An unexpected balance bill from an out-of-network provider is also called a surprise medical bill. People with Medicare and Medicaid already enjoy these protections and are not at risk for surprise billing.

What are the new protections if I have health insurance?

If you get health coverage through your employer, a Health Insurance Marketplace®, [1] or an individual health insurance plan you purchase directly from an insurance company, these new rules will:

- Ban surprise bills for most emergency services, even if you get them out-of-network and without approval beforehand (prior authorization).
- Ban out-of-network cost-sharing (like out-of-network coinsurance or copayments) for most emergency and some non-emergency services. You can't be charged more than in-network cost-sharing for these services.
- Ban out-of-network charges and balance bills for certain additional services (like anesthesiology or radiology) furnished by out-of-network providers as part of a patient's visit to an in-network facility.
- Require that health care providers and facilities give you an easy-to-understand notice explaining the applicable billing protections, who to contact if you have concerns that a provider or facility has violated the protections, and that patient consent is required to waive billing protections (i.e., you must receive notice of and consent to being balance billed by an out-of-network provider).

[1] Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.

What if I don't have health insurance or choose to pay for care on my own without using my health insurance (also known as "self-paying")?

If you don't have insurance or you self-pay for care, in most cases, these new rules make sure you can get a good faith estimate of how much your care will cost before you receive it.

What if I'm charged more than my good faith estimate?

For services provided in 2022, you can dispute a medical bill if your final charges are at least $400 higher than your good faith estimate and you file your dispute claim within 120 days of the date on your bill.

What if I do not have insurance from an employer, a Marketplace, or an individual plan? Do these new protections apply to me?

Some health insurance coverage programs already have protections against surprise medical bills. If you have coverage through Medicare, Medicaid, or TRICARE, or receive care through the Indian Health Services or Veterans Health Administration, you don't need to worry because you're already protected against surprise medical bills from providers and facilities that participate in these programs.

What if my state has a surprise billing law?

The No Surprises Act supplements state surprise billing laws; it does not supplant them. The No Surprises Act instead creates a "floor" for consumer protections against surprise bills from out-of-network providers and related higher cost-sharing responsibility for patients. So as a general matter, as long as a state's surprise billing law provides at least the same level of consumer protections against surprise bills and higher cost-sharing as does the No Surprises Act and its implementing regulations, the state law generally will apply. For example, if your state operates its own patient-provider dispute resolution process that determines appropriate payment rates for self-pay consumers and Health and Human Services (HHS) has determined that the state's process meets or exceeds the minimum requirements under the federal patient-provider dispute resolution process, then HHS will defer to the state process and would not accept such disputes into the Federal process.

As another example, if your state has an All-Payer Model Agreement or another state law that determines payment amounts to out-of-network providers and facilities for a service, the All-Payer Model Agreement or other state law will generally determine your cost-sharing amount and the out-of-network payment rate.

Where can I learn more?

Still have questions? Visit **CMS.gov/nosurprises**, or call the Help Desk at 1-800-985-3059 for more information. TTY users can call 1-800-985-3059.

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost

Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.

- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.

- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 1-800-985-3059.

Disclaimer

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, and your bill is $400 or more for any provider or facility than your Good Faith Estimate for that provider or facility, federal law allows you to dispute the bill.

If you are billed for more than this Good Faith Estimate, you may have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

If you dispute your bill, the provider or facility cannot move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, the provider or facility has to cease collection efforts. The provider or facility must also suspend the accrual of any late fees on unpaid bill amounts until after the dispute resolution process has concluded. The provider or facility cannot take or threaten to take any retributive action against you for disputing your bill.

There is a $25 fee to use the dispute process. If the Selected Dispute Resolution (SDR) entity reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate, reduced by the $25 fee. If the SDR entity disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises/consumers or call 1-800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises/consumers email FederalPPDRQuestions@cms.hhs.gov or call 1-800-985-3059.

Keep a copy of your Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

PRIVACY ACT STATEMENT: CMS is authorized to collect the information on this form and any supporting documentation under section 2799B-7 of the Public Health Service Act, as added by section 112 of the No Surprises Act, title I of Division BB of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260). We need the information on the form to process your request to initiate a payment dispute, verify the eligibility of your dispute for the PPDR process, and to determine whether any conflict of interest exists with the independent dispute resolution entity selected to decide your dispute. The information may also be used to: (1) support a decision on your dispute; (2) support the ongoing operation and oversight of the PPDR program; (3) evaluate selected IDR entity's compliance with program rules. Providing the requested information is voluntary. But failing to provide it may delay or prevent processing of your dispute, or it could cause your dispute to be decided in favor of the provider or facility.

Tiene derecho a recibir una "Estimación de buena fe" que explique cuánto costará su atención médica.

Según la ley, los proveedores de atención médica deben dar a los **pacientes que no tienen o no usan seguro** una estimación de la factura de los artículos y servicios médicos.

- Tiene derecho a recibir una estimación de buena fe por el costo total esperado de cualquier artículo o servicio que no sea de emergencia. Esto incluye costos relacionados como exámenes médicos, medicamentos recetados, equipos y tarifas del hospital.

- Asegúrese de que su proveedor de atención médica le dé una estimación de buena fe por escrito al menos 1 día hábil antes de recibir su servicio o artículo médico. También puede pedirle a su proveedor de atención médica, y a cualquier otro proveedor que elija, una estimación de buena fe antes de programar un artículo o servicio.

- Si recibe una factura de al menos $400 más que su estimación de buena fe, puede disputar la factura.

- Asegúrese de guardar una copia o una foto de su estimación de buena fe.

Si tiene preguntas o para obtener más información sobre su derecho a recibir una estimación de buena fe, visite www.cms.gov/nosurprises o llame al 1-800-985-3059.

Surprise Billing Protection Form

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider when you received care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

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're getting this notice because this provider or facility isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan.

Getting care from this provider or facility could cost you more.

If your plan covers the item or service you're getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your health care provider or patient advocate if you need help knowing if these protections apply to you.

If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

You **shouldn't** sign this form if you **didn't** have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one.

See the next page for your cost estimate.

Estimate of what you could pay

Patient name:____

Out-of-network provider(s) or facility name:______________________________

____

Total cost estimate of what you may be asked to pay:	

► **Review your detailed estimate.** See Page 4 for a cost estimate for each item or service you'll get.

► **Call your health plan.** Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan and your provider options.

► **Questions about this notice and estimate?**

► **Questions about your rights?** Contact 1-800-985-3059 or https://www.cms.gov/nosurprises

Prior authorization or other care management limitations

[*Enter either (1) specific information about prior authorization or other care management limitations that are or may be required by the individual's health plan or coverage, and the implications of those limitations for the individual's ability to receive coverage for those items or services, or (2) include the following general statement:*

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover an item orservice before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.]

[*In the case where this notice is being provided for post-stabilization services by a nonparticipating provider within a participating emergency facility, include the language immediately below and enter a list of any participating providers at the facility that are able to furnish the items or services described in this notice]*

Understanding your options

You can also get the items or services described in this notice from these providers who are in-network with your health plan:

More information about your rights and protections

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.

With my signature, I am saying that I agree to get the items or services from (select all that apply):

☐ [*doctor's or provider's name*] [*If consent is for multiple doctors or providers, provide a separate check box for each doctor or provider]*

☐ *[facility name]*

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services,or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on [*enter date of notice*] explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You **don't** have to sign this form. But if you don't sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan's network.

______________________	or	______________________
Patient's signature		Guardian/authorized representative's signature
______________________		______________________
Print name of patient		Print name of guardian/authorized representative
______________________		______________________
Date and time of signature		Date and time of signature

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.

More details about your estimate

Patient name: ____

Out-of-network provider(s) or facility name: ____

____

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. This means that **the final cost of services may be different than this estimate**.

Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.

[Enter the good faith estimated cost for the items and services that would be furnished by the listed provider or facility plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services. Assume no coverage would be provided for any of the items and services.].

[Populate the table below with each item and service, date of service, and estimated cost. Add additional rows if necessary. The total amount on page 2 must be equal to the total of each of the cost estimates included in the table.]

Date of service	Service code	Description	Estimated amount to be billed
		Total estimate of what you may owe:	

Addendum – State Contacts & Consumer Protection Information

State	Department of Attorney General	Surprise Billing or Department of Insurance	State Balance Billing Website
CA	https://oag.ca.gov/contact/consumer-complaint-against-business-or-company	www.HealthHelp.ca.gov 1-888-466-221	https://dmhc.ca.gov/portals/0/healthcareincalifornia/factsheets/fsab72.pdf
CT	https://portal.ct.gov/AG/Common/Complaint-Form-Landing-page	https://portal.ct.gov/CID/Consumer-Affairs/File-a-Complaint-or-Ask-a-Question Consumer Helpline: 1-800-203-3447 or 1-860-297-3900	https://portal.ct.gov/CID/General-Consumer-Information/No-Surprises-Act
DE	https://insurance.delaware.gov/	https://legis.delaware.gov/SessionLaws/Chapter?id=19067#:~:text=%22(11)%20'Balance%20billing,will%20pay%20for%20the%20service.%22&text=Arbitration%20of%20disputes%20involving%20health%20insurance%20coverage domestic-foreign-insurers-bulletin	https://attorneygeneral.delaware.gov/fraud/cmu/complaint/
FL	http://www.myfloridalegal.com/pages.nsf/Main/E3EB45228E9229DD85257B05006E32EC 1-877-693-5236 1-850-413-3089 Consumer.Services@myfloridacfo.com	https://floir.com/Sections/LandH/AccidentHealth/EducationalMaterials.aspx	Consumer.Services@myfloridacfo.com
GA	https://consumer.georgia.gov/resolve-your-dispute/how-do-i-file-complaint/consumer-complaint-form#no-back 1-404-651-8600 or 1-800-869-1123	https://oci.georgia.gov/file-consumer-insurance-complaint	https://oci.georgia.gov/news/2020-12-30/office-commissioner-insurance-and-safety-fire-posts-final-surprise-billing
IA	https://www.iowaattorneygeneral.gov/for-consumers/file-a-consumer-complaint	https://iid.iowa.gov/insurance-consumer-complaint	https://www.iowaattorneygeneral.gov/for-consumers/file-a-consumer-complaint/complaint-form

State	Department of Attorney General	Surprise Billing or Department of Insurance	State Balance Billing Website
ID	https://www.ag.idaho.gov/consumer-protection/consumer-complaints/	https://doi.idaho.gov/consumers/file-a-complaint/	Law has not yet passed
IL	Health Care Bureau Complaint Form (illinoisattorneygeneral.gov)	https://www.in.gov/healthcarereform/no-surprises-act/#:~:text=It%20applies%20to%20self%2Dinsured,sharing%20amount%20for%20emergency%20services	Understanding the Insurance Complaint Process (illinois.gov) http://iga.in.gov/legislative/2020/bills/house/1004#digest-heading https://legiscan.com/IN/bill/HB1004/2020 Healthcare Reform: FAQs with Examples of the No Surprise Act Protections (in.gov)
IN	https://www.in.gov/attorneygeneral/consumer-protection-division/file-a-complaint/	https://www.in.gov/idoi/consumer-services/complaints/	https://legiscan.com/IN/bill/HB1004/2020
MD	https://www.marylandattorneygeneral.gov/pages/cpd/complaint.aspx	https://insurance.maryland.gov/Consumer/Pages/FileAComplaint1.aspx	https://insurance.maryland.gov/Consumer/Documents/publications/AssignmentofBenefitsFAQ.pdf
MA	https://www.mass.gov/how-to/file-a-health-care-complaint	https://www.mass.gov/how-to/filing-an-insurance-complaint	https://www.mass.gov/news/pricing-transparency-provisions-of-an-act-promoting-a-resilient-health-care-system-that-puts-patients-first-patients-first
MI	https://www.michigan.gov/documents/ag/Consumer_Complaint_Form_-_paper_642450_7.pdf	https://www.michigan.gov/difs/0,5269,7-303--560598--,00.html 1-833-ASK-DIFS 1-833-275-3437	https://www.michigan.gov/som
MN	https://www.ag.state.mn.us/Office/Complaint.asp	https://mn.gov/commerce/consumers/file-a-complaint/complaints/	https://www.health.state.mn.us/facilities/insurance/managedcare/faq/nosurprisesact.html
NE	https://ago.nebraska.gov/	https://doi.nebraska.gov/consumer/consumer-help	https://www.nebraska.gov/apps-ago-complaints/?preSelect=CP_COMPLAINT
NJ	https://www.njoag.gov/contact/file-a-complaint/	https://www.nj.gov/dobi/division_consumers/insurance/outofnetwork.html	https://www.nj.gov/dobi/division_insurance/oonarbitration/data/210131report.html

State	Department of Attorney General	Surprise Billing or Department of Insurance	State Balance Billing Website
NY	https://ag.ny.gov/consumer-frauds/Filing-a-Consumer-Complaint	https://www.dfs.ny.gov/complaint	https://www.dfs.ny.gov/consumers/health_insurance/surprise_medical_bills
OH	https://www.ohioattorneygeneral.gov/Individuals-and-Families/Consumers/File-a-Complaint	https://insurance.ohio.gov/strategic-initiatives/surprise-billing/resources/file-surprise-billing-complaint	https://insurance.ohio.gov/strategic-initiatives/surprise-billing
OR	https://www.doj.state.or.us/wp-content/uploads/2017/08/consumer_complaint.pdf	https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx 1-888-877-4894	https://dfr.oregon.gov/news/2018/Pages/20180301-balance-billing.asp
PA	https://www.attorneygeneral.gov/submit-a-complaint/health-care-complaint/	No Surprises Bill Review Request Form (powerappsportals.us)	Home (pa.gov)

State Balance Billing Laws and Requirements

(Published State Summaries Provided Below)

State	Emergency Services	Services at an in-network hospital or ambulatory surgical center and other protections
CA	No State Summary Issued	
CT	No State Summary Issued	
DE	No State Summary Issued	
FL	No State Summary Issued	
GA	No State Summary Issued	
IA	No State Summary Issued	
ID	No State Law	
IL	No State Summary Issued	
IN	No State Summary Issued	
MD	If you are in a Health Maintenance Organization (HMO) governed by Maryland, you may not be balanced billed for services covered by your plan, including ground ambulance services. If you are in a PPO or EPO governed by Maryland law, hospital-based or on-call physicians paid directly by your PPO or EPO (assignment of benefits) may not balance bill you for services covered under your plan and can't ask you to waive your balance billing protections. If you use ground ambulance services operated by a local government provider who accepts an assignment of benefits from a plan governed by Maryland law, the provider may not balance bill you. If you believe you've been wrongly billed, you may contact the Health Education and Advocacy Unit (HEAU) of Maryland's Consumer Protection Division: Health Education and Advocacy Unit, Office of the Attorney General, 200 St. Paul Place, 16th Floor, Baltimore, Maryland 21202, Phone: (410) 528-1840 or toll free 1 (877) 261-8807, En español: 410-230-1712, Fax: (410) 576-6571, heau@oag.state.md.us, website: http://www.marylandattorneygeneral.gov/Pages/CPD/HEAU If you believe your health plan processed your claim incorrectly, you may contact the Maryland Insurance Administration: Maryland Insurance Administration, Life and Health Complaints Unit, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202, Phone (410) 468-2260, website: http://www.insurance.maryland.gov	
MA	No State Summary Issued	
MI	No State Summary Issued	
MN	No State Summary Issued	
NE	No State Summary Issued	
NJ	No State Summary Issued	
NY	You only have to pay your in-network cost-sharing (copayment, coinsurance, and deductible) for bills for out-of-network emergency services in a hospital. • This includes bills from doctors, the hospital*, and beginning in January 2022, any other providers who treat you.	Surprise bills happen when an out-of-network provider treats you at an in-network hospital or ambulatory surgical center OR you are referred by an in-network doctor to an out-of-network provider. (In-network means in your health plan's network.) You only have to pay your in-network cost-sharing for a surprise bill. **It's A Surprise Bill At An In-Network Hospital or Ambulatory Surgical Center if an Out-of-Network Provider Treats You and**:

	• This includes inpatient services if you are admitted to the hospital after your emergency room visit. • Your provider may only bill you for your in-network cost-sharing (copayment, coinsurance, or deductible) for emergency services, including inpatient services which follow an emergency room visit. • Let your health plan know if you receive a bill from an out-of-network provider for emergency services.	• An in-network provider was not available; OR • An out-of-network provider provided services without your knowledge; OR • Unforeseen medical services were provided when you received health care services. It is NOT a surprise bill if you chose to receive services from an out-of-network provider instead of from an available in-network provider before you got to the hospital or ambulatory surgical center. Beginning January 1, 2022, the following services will usually be a surprise bill when provided by an out-of-network provider in a hospital or ambulatory surgical center: emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. If your health care services were **before January 1, 2022**, you are only protected from a surprise bill if you were treated by an out-of-network physician (and not other health care providers) at an in-network hospital or ambulatory surgical center. **It's a Surprise Bill When Your In-Network Doctor Refers You to an Out-of-Network Provider if**: • You did not sign a written consent that you knew the services were out-of-network and would not be covered by your health plan; AND • During a visit with your participating doctor, a non-participating provider treats you; OR • Your in-network doctor takes a specimen from you in the office (for example, blood) and sends it to an out-of-network laboratory or pathologist; OR • For any other health care services when referrals are required under your plan. **If You Get a Surprise Bill Because An Out-of-Network Provider Treats You At An In-Network Hospital Or Ambulatory Surgical Center OR Your Doctor Refers You To An Out-of-Network Provider**: • You only have to pay your in-network cost-sharing. • If an out-of-network provider bills you for any amount over your in-network cost-sharing (copayment, coinsurance, or deductible) this is called balance-billing. • If your doctor referred you to an out-of-network provider, you MUST send a Surprise Bill Certification Form to your health plan and your provider to make sure that they know you

		received a Surprise Bill and that you must be protected from balance billing. • If an out-of-network provider treats you at an in-network hospital or ambulatory surgical facility, you MUST send a Surprise Bill Certification Form to your health plan and your provider if you received the health care services before January 1, 2022 to make sure that they know you received a Surprise Bill and that you must be protected from balance billing. The form is not required for services provided after January 1, 2022 at an in-network hospital or ambulatory surgical facility, but it is recommended. You may also file a complaint with DFS.
OH	Ohioans who get health insurance through plans regulated by the Ohio Department of Insurance are also protected from receiving surprise medical bills under Ohio law. Ohio law provides the following protections when you receive unanticipated out-of-network care: • No balance billing for emergency services, including emergency services provided by an ambulance, even if they're provided out-of-network. • No balance billing by out-of-network providers at an in-network facility when you're unable to choose an in-network provider. • Your cost-sharing amounts, such as copayments, coinsurance, and deductibles, are limited to the amount you would pay for in-network services. Health plans regulated by the state of Ohio should have the letters "ODI" clearly denoted on your insurance identification card. You can find additional information at Surprise Billing | Department of Insurance (ohio.gov).	
OR	No State Summary Issued	
PA	HMOs and PPOs are required to protect their enrollees	No Law