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 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 the provider and the full amount charged by the provider. 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 innetwork 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, 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 a stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

California law protects patients enrolled in state regulated plans from surprise medical bills when a patient receives emergency services from a doctor or hospital that is not contracted with the patient's health plan or medical group. In covered circumstances, providers cannot bill patients for more than their in-network cost sharing.

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 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 balanced 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.

California law protects patients enrolled in state regulated plans from surprise medical bills when the patient receives scheduled care at an in-network facility such as a hospital, lab, or imaging center, but services are delivered by an out-of-network provider. In covered circumstances, providers cannot bill patients more than their in-network cost sharing. Further, for uninsured individuals, hospitals must provide the patient with a written estimate of the amount the hospital will require for the expected services at the time of service.

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

- You're only responsible for paying your share of the cost (like 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.

If you think you've been wrongly billed, you may file a complaint with your health insurer with a copy of the bill. If you do not agree with your health insurer's response, you can file a complaint with the California Department of Managed Health Care at 1-888-466-2219. Visit www.HealthHelp.ca.gov for more information about your rights under state law.

For federally regulated plans, including "self-insured" plans and Medicare Advantage plans, please call 1-800-985-3059 or go to https://www.cms.gov/nosurprises/consumers).

The federal phone number for information and complaints is: 1-800-985-3059 or submit a complaint on the web form: CMS Web Form. Visit www.cms.gov/nosurprises/ for more information about your rights under federal law.