Your Rights and Protections Against Surprise Medical Bills

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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 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, 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.

California law: For plans regulated by California (Knox-Keene health care service plans and insurance policies subject to AB 72), you are also protected from balance billing for emergency services. You are only responsible for your in-network cost-sharing amount.

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 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.
California law (AB 72, Health & Safety Code § 1371.30): If you have a plan regulated by the California Department of Managed Health Care or the California Department of Insurance, an out-of-network provider generally cannot bill you more than your in-network cost-sharing amount for non-emergency services you receive at an in-network facility. Under California law, if you choose to receive care from an out-of-network provider at an in-network facility, you must be given a written consent form—separate from any other document—at least 24 hours in advance, along with a written estimate of your total out-of-pocket cost, and you must be told that you may instead be treated by an in-network provider.

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 (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

Federal: Contact the No Surprises Help Desk at 1-800-985-3059. Visit www.cms.gov/nosurprises for more information about your rights under federal law.

California – Department of Managed Health Care (most HMOs and many PPOs): Contact the DMHC Help Center at www.DMHC.ca.gov or 1-888-466-2219.

California – Department of Insurance (insurance policies/PPOs): Contact the CDI Consumer Hotline at www.insurance.ca.gov or 1-800-927-4357.

Note: *If your plan is regulated by California, file a complaint with your health plan or insurer first, with a copy of the bill. If it is not resolved within 30 days, contact the DMHC or CDI as above.*