Your Rights and Protections Against Surprise Medical Bills

Effective January 1, 2022, the No Surprises Act, which Congress passed as part of the Consolidated Appropriations Act of 2021, is designed to protect patients from surprise bills for emergency services at out-of-network facilities or for out-of-network providers at in-network facilities, holding them liable only for in-network cost-sharing amounts. The No Surprises Act also enables uninsured patients to receive a good faith estimate of the cost of care.

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 balanced billed for these post-stabilization services.

Additionally, California law protects patients with coverage through plans regulated by the California Department of Managed Care from balance billing when the patient receives emergency services from an out-of-network doctor or hospital. This protection only requires patients to pay their in-network cost sharing amounts.

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.

Additionally, California law protects patients with health care service plans from balance billing when patients receive covered services at an in-network facility by an out-of-network provider. This protection requires patients to only pay their in-network cost-sharing amount. If the patient consents to services in advance, the balance billing prohibition does not apply.

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 (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 believe you've been wrongly billed, you may contact:

- The U.S. Centers for Medicare & Medicaid Services (CMS) at 1-800-MEDICARE (1-800-633-4227) or visit
- https://www.cms.gov/nosurprises
- for more information about your rights under federal law.
- The California Department of Managed Health Care at 1-888-466-2219 or visit
- https://drbarnett.com/wp-content/uploads/2022/06/fsab72.pdf
- for more information about your rights under California law.
- The California Department of Insurance at 1-800-927-4357 or visit
- https://www.insurance.ca.gov/01-consumers/110-health/60-resources/NoSupriseBills.cfm
- for more information about your rights under California law.

If you do not know what kind of plan you have, you can call the California Department of Insurance Help Center at 1-800-927-4357.

CALIFORNIA POLICY

(**https://www.insurance.ca.gov/01-consumers/110-health/60-resources/NoSuprise Bills.cfm**)

Consumer Protection from Surprise Medical Bills

What is a surprise bill?

Before July 1, 2017, consumers sometimes received unexpected bills from out-of-network providers when they sought services at an in-network facility. The bills were a result of a billing disagreement between insurers and out-of-network providers.

Here are some examples of when consumers have gotten surprise bills in the past:

- A consumer had a surgery at an in-network hospital, but the anesthesiologist who provided care was not in their health insurer network. Even though the consumer did not have a choice in who their anesthesiologist was, that provider sends a bill to the consumer after the surgery.
- A consumer goes to an in-network lab or imaging center for tests and the doctor who reads the results is not in their health insurer's network. That doctor then bills the consumer for their services creating a surprise bill.

No more surprise medical bills:

Consumers are no longer put in the middle of billing disputes between health insurers and out-of-network providers when seeking non-emergency services. Consumers can only be billed for their in-network cost-sharing (co-pays, co-insurance or deductible), when they use an in-network facility for non-emergency care.Beginning July 1, 2017, California law protects consumers from surprise medical bills when they get non-emergency services, go to an in-network health facility and receive care from an out-of-network provider without their consent. In this case, the law states that consumers only have to pay their in-network cost sharing. Medical providers are prohibited from sending consumers out-of-network bills when the consumer followed their health insurer's requirements and received non-emergency services in an in-network facility. Facilities include hospitals, ambulatory surgery centers or other outpatient settings, laboratories, and radiology and imaging centers.Consumers following their health insurer's requirements are protected from having their credit hurt, wages garnished, or liens placed on their primary residence.

Frequently Asked Questions:

What if I received a surprise bill? And what if I already paid it?

If you received a surprise bill for medical services provided after July 1, 2017 and already paid more than your in-network cost share (co-pay, co-insurance or deductible) file a complaint with your health insurer with a copy of the bill. Your health insurer will review your complaint and should tell the provider to stop billing you. If you do not agree with your health insurer's response or would like help from the California Department of Insurance to fix the problem, you can file a complaint with us online or by calling 1-800-927-4357.

Does AB 72 apply to everyone?

The new law created by AB 72 applies to people with health insurance policies or plans regulated by the Department of Insurance or the California Department of Managed Health Care that were issued, amended, or renewed on or after July 1, 2017. It does not apply to Medi-Cal plans, Medicare plans or self-insured plans. If you do not know what kind of plan you have, you can call the Department of Insurance Help Center at 1-800-927-4357.

What if I want to see a doctor who I know is out-of-network?

If you have a health insurance policy with an out-of-network benefit, such as a PPO, you can choose to go to an out-of-network provider. If you go to an in-network facility and want to see an out-of-network provider, you have to give your permission in writing by signing a form provided by the out-of-network provider at least 24 hours before you receive care. The form must be separate from any other document used to obtain consent for any other part of the care or procedure and should inform you that you can receive care from an in-network provider if you choose. At the time consent is provided, the out-of-network provider shall give the consumer a written estimate of the consumer's total out-of-pocket cost of care.

If you have any questions about a surprise bill, please contact the Department's Help Center online or call us at 1-800-927-4357.

How do I file a "Consumer Complaint Against a Business/Company"?

https://oag.ca.gov/contact/consumer-complaint-against-business-or-company

Good Faith Estimate

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- 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 healthcare provider gives you a Good Faith Estimate in writing at least one business day before your medical service or item. You can also ask your healthcare 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.

Get More Information

For questions or more information about your right to a Good Faith Estimate, visit **cms.gov/nosurprises** or call 1-800-MEDICARE (1-800-633-4227).