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 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 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 stable condition, unless you give written consent and give up your protections not to be balanced 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 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 Laws
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.

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 think you've been wrongly billed, contact California Department of Insurance by calling 1-800-927-4357 or visiting https://www.insurance.ca.gov/01-consumers/101-help/index.cfm. The federal phone number for information and complaints is: 1-800-985-3059.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law. Visit https://www.insurance.ca.gov/01-consumers/110-health/60-resources/ or for more information about your rights under California state laws.