

Your Rights and Protections Against Surprise Medical Bills

What is “balance billing” (sometimes called “surprised 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 must 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 to 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 plans 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. For example, 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.

Your 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 for is your plans in-network-cost-sharing amount (such as copayments, coinsurance, and deductibles.) You can not 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.

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 plans 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** and they **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.



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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 think you've been wrongly billed:

- File a grievance/complaint with your health insurance company and include a copy of the bill. Your health insurance company will review the complaint and should contact the provider on your behalf to stop billing you.
- If you do not agree with your health insurance's response or they take more than 30 days to fix the issue you may file a complaint with the California Department of Insurance. Patients may reach the California Department of Insurance by calling **1-800-927-4357** or visiting their website at **insurance.ca.gov**