NO SURPRISE BILLING NOTICE

The federal No Surprises Act 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. Patient shall only be responsible for in-network cost-sharing amounts for emergency service. Under the No Surprises Act, uninsured patients have the right to receive a good faith estimate of the cost of care.

Billing Disclosures – Your Rights and Protections Against Surprise Medical Bills

When you get emergency care at an out-of-network hospital, or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other healthcare provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a healthcare facility that isn't in your health plan's network.

“Out-of-network” describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay 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 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.

You are 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 the provider or facility may bill you is your insurance plan’s in-network cost-sharing amount (such as copayments and coinsurance). 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 may 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 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 care out-of-network. 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 the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally 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 deductible and out-of-pocket limit.

Obtain More Information

For more information, or if you believe you have been wrongly billed, you may contact:

- The hospital's billing office at 760-499-3010.
- Call your health plan for more information about much you may need to pay and your options for other providers.
- The U.S. Centers for Medicare & Medicaid Services (CMS) at **1-800-MEDICARE** (**1-800-633-4227**) or visit **cms.gov/nosurprises/consumers** for more information about your rights under federal law.
- The California Department of Managed Health Care at **1-888-466-2219** or visit **https://dmhc.ca.gov/portals/0/healthcareincalifornia/factsheets/fsab72.pdf** or for more information about your rights under California law.
- The California Department of Insurance at **1-800-927-4357** or visit **www.insurance.ca.gov/01-consumers/110-health/60-resources/NoSupriseBills** for more information about your rights under California law.

If you do not know what kind of plan you have, and for assistance with other billing and coverage issues, call the hospital's billing department at 760-499-3010.