HOLLYWOOD PRESBYTERIAN
MEDICAL CENTER

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care 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 health care 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 health care 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—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.

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 plan's in- network cost sharing amount (such as copayments and coinsurance or a deductible). For emergency services, out of network providers may not bill you for the balance between in network and out of network charges. This includes services you may get after you are in stable condition, unless you give written consent and to be balanced billed for these post-stabilization services.

California laws also protect consumers from surprise medical bills and prohibit balance billing when you receive emergency services (such as a hospital, lab or imaging center), provided by an out-of-network doctor or hospital. The consent needs to be 24 hours in advance for private health plan covered patients and 72 hours in advance federally funded plans.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital, ambulatory surgical center, or other types of facilities such as imaging 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 are not permitted to balance bill you and may

not ask you to give up your protections not to be balance billed. If you receive services from other types of providers at these in-network facilities, out-of-network providers cannot balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing is not 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.

If you believe you have been wrongly billed, please see the contact information below for the appropriate agency to contact.

- If you are covered by a California-regulated HMO, an Anthem Blue Cross of California PPO, or a Blue Shield of California PPO, you can contact the California Department of Managed Health Care's Help Center at 1-888-466-2219, or file a complaint at https://www.dmhc.ca.gov/file-acomplaint/contact-your-health-plan.aspx.

- If you are covered by a California-regulated insurance company (which includes most PPOs except those offered by Anthem Blue Cross of California and Blue Shield of California), you can contact the California Department of Insurance's consumer help line at 1-800-927-4357, or file a complaint at http://www.insurance.ca.gov/01-consumers/101-help/index.cfm. Visit https://cms.gov/nosurprises/consumer-protections or call 1-800-985-3059 for more information about your rights under federal law.

- Visit https://www.dmhc.ca.gov/Portals/0/HealthCareInCalifornia/FactSheets/fsab72.pdf or https://www.insurance.ca.gov/01-consumers/110-health/60-resources/NoSupriseBills.cfm for more information about your rights under California law.