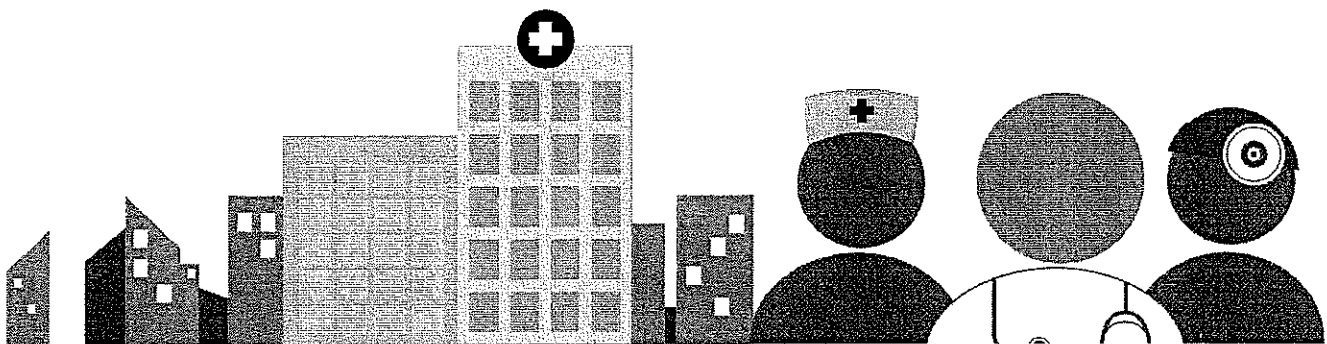


Here are some examples of when consumers have received surprise medical bills:

- A consumer had a surgery at an in-network hospital or outpatient surgery center, but the anesthesiologist was not in their health plan network. Even though the consumer did not have a choice of who their anesthesiologist was, that provider sends a bill to the consumer after the surgery. This is a surprise balance bill.
- 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 plan network. That doctor then bills the consumer for their services, creating a surprise balance bill.
- A consumer is taken to the nearest emergency room, however, the emergency facility is not contracted with the consumer's health plan. The consumer later receives a bill from the emergency facility for the remaining balance of the bill that was not paid by their health plan. This is a type of surprise bill known as emergency balance billing.

What if I get a surprise bill?

If you get a surprise bill for more than your in-network cost share, file a grievance/complaint with your health plan and include a copy of the bill. Your health plan will review your grievance and should tell the provider to stop billing you. If you do not agree with your health plan's response or they take more than 30 days to fix the problem, you can file a complaint with the Department of Managed Health Care, the state regulator of health plans. You can file a complaint by visiting www.HealthHelp.ca.gov or calling 1-888-466-2219.



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.

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