

FOR IMMEDIATE RELEASE

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YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

[Fresno, CA, October 1, 2022] – In the closing days of 2020, Congress enacted, and the President signed into law the “No Surprises Act,” which contains key protections to hold consumers harmless from the cost of unanticipated out-of-network medical bills. While California law already provides similar consumer protections, healthcare consumers will now benefit from the new federal law as well.

This is important to you as a healthcare consumer, because when you receive emergency care or are treated by an out-of-network doctor or specialist at a hospital or ambulatory surgical center in your plan's network, 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 specialist, you may owe certain out-of-pocket costs, such as a copay, coinsurance, and/or a deductible. If you see a doctor or specialist or visit a healthcare facility that isn't in your health plan's network, you might owe additional charges or be responsible for the entire bill.

- **“Out-of-network”** describes doctors and healthcare facilities that haven't signed a contract with the health plan. Out-of-network doctors and facilities may be allowed 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 at a non-contracted emergency room or when you schedule a visit at a facility in your plan's network but are unexpectedly treated by an out-of-network doctor (such as an anesthesiologist) whom you did not choose.

Under the No Surprises Act*, you are protected from balance billing for:

Emergency services

If you have an emergency medical situation and receive emergency services from an out-of-network doctor or facility, the most the doctor or facility may bill you is your plan's in-network cost-sharing amount (such as copays and coinsurance).

- You cannot be balance billed for these emergency services.
- This includes services you may receive after you're in stable condition unless you give written consent to give up your protections against balance billing once you're stable.

Certain services at a hospital or ambulatory surgical center in your plan's network

When you receive services from a hospital or ambulatory surgical center (places that perform outpatient surgeries) in your plan's network, certain doctors or specialists there may be out-of-network.

- In these cases, the most they may bill is the plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services.
- These specialists cannot balance bill you and cannot ask you to give up your protections not to be balance billed.
- If you receive other services at these in-network facilities, out-of-network doctors or other healthcare professionals cannot balance bill you, unless you give written consent to give up your protections.

You're never required to give up your protections against balance billing. You also aren't required to receive care out of your plan's network.

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 copay, coinsurance, and deductibles that you would pay if the doctor or facility was in your plan's network). Your health plan will pay out-of-network doctors and facilities directly.

Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (also called prior authorization).
- Cover emergency services by out-of-network doctors or specialists.
- Base what you owe the doctor or facility (cost-sharing) on what it would pay a doctor or facility in your plan's network 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 think you've been wrongly billed, you can contact the Employee Benefits Security Administration (EBSA) to ask whether the charges are allowed by law.

Should you questions, contact CVT Member Services at (800) 288-9870.

**Effective for most CVT plans starting October 1, 2022.*

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Established in 1984, California's Valued Trust (CVT) remains today as one of California's largest self-funded public schools trusts specializing in healthcare benefits for the education community. As a jointly managed trust, CVT is governed by a Board of Directors which is equally comprised of union and management representatives. The board works collaboratively with the CVT staff to identify, negotiate and purchase the highest quality health benefit programs for all of our members throughout California. CVT serves more than 234 districts and 158,000 members throughout California. For more information, visit www.cvtrust.org.