# No Surprises Act

"Surprise billing" describes an unexpected medical balance bill. This can happen when you cannot choose who is involved in your care, such as if you have an emergency or if you are treated by a physician or care provider who is not participating in your insurance network.

**When are you protected from balance billing?**

**Emergency services:** If you have a health emergency and you receive 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 or coinsurance. You CANNOT be balance billed for emergency services or for the care that you get after your condition is stabilized unless you give written consent and give up your protections not to be balance-billed for these services.

**Out-of-network providers at an in-network facility:** When you receive care from an in-network hospital or surgical hospital certain providers who work there may not be in your plan network. Those providers may bill you the amount you would pay if the provider were in your network. This includes emergency services, anesthesia, pathology, radiology, laboratory charges, assistant surgeon, hospitalists and intensivists. In this situation they cannot balance bill you and they are prohibited from asking you to give up your protections not to be balance-billed.

**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.**

**You also have the additional protections:**

You are only responsible for paying your share of the cost (such as copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). The health plan is required to pay out-of-network providers and facilities directly.

If you have health insurance and you are seeing a provider that **is in your network**, you have the right to request a Good Faith Estimate of what you will owe for scheduled services. Our office is required to provide you with the codes that we expect to bill and our charge. With that information you can contact your insurance carrier and they are required to provide you with their allowable and the amount that you will owe based on your deductible, copayment or co-insurance and your personal or family out-of-pocket maximum.

If you have health insurance but you are seeing a provider that is **not in your network**, you have the same right for the Good Faith Estimate, but you are also encouraged to ask your insurance company to provide you with a list of in-network resources. Always seeking non-emergency care within your network will ultimately cost less. You should also be asked to sign an "Out of Network" Consent form prior to receiving the service described in the estimate.

Insurance companies have also been advised to re-issue insurance cards that have more information easily located on the card, such as the amount of copay or co-insurance, the deductible amount, and if there is a requirement that your Primary Care Provider is managing your care by issuing authorizations for you to see other medical providers. **If you receive a new card from your carrier, PLEASE remember to bring it on your next visit!**

**Your health plan generally must:**

- Cover emergency services without requiring you to get approval in advance.
- 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 towards your in-network deductible and out-of-pocket limits.

If you **do not have health insurance**, you are also encouraged to request a Good Faith Estimate under the No Surprises Act. Your Good Faith Estimate should contain the following information:

- Your name and date of birth
- A description of the service to be provided
- Applicable diagnosis and service codes with expected charges listed for each service
- An itemized list of other items or services that may be required during the period of care
- A disclaimer alerting you to your right to initiate a patient-provider dispute resolution process if the billed charges are "substantially in excess" of the Good Faith Estimate.

If you believe that you have been wrongly billed you may contact Oklahoma Insurance Department at 400 NE 50th Street in Oklahoma City, Oklahoma 73105 (Phone: 405-521-2828 or Toll Free 800-522-0071) or the Centers for Medicare and Medicaid at the No Surprises Help Desk at 800-985-3059. Visit https://www.cms.gov/nosurprises for more information about your rights under Federal law.