Notice of Surprise Billing Protections

RIVERS ORAL FACIAL & IMPLANT SURGERY

The No Surprises Act requires health care providers, facilities, health plans, health insurance issuers and Federal Employees Health Benefits (FEHB) Program carriers to notify consumers about their surprise billing protections. In general, providers and facilities that furnish items or services at a health care facility (such as hospitals and ambulatory surgical centers), or in connection with visits at health care facilities, must give this notice to individuals who have health plans or coverage subject to the No Surprises Act. Providers and facilities shouldn't give these notices to an individual whose only coverage is Medicare, Medicaid, or any other form of coverage not subject to the No Surprises Act, or to an individual who is uninsured. The notices must:

- Explain federal surprise billing restrictions;
- Identify and explain any applicable state law protections against surprise billing; and
- Identify how to contact the appropriate state and federal agencies in cases where protections may have been violated.

How the Notice Must Be Provided

Entity Providing Notice	Posted Publicly	Website	Other
Providers and facilities	Publicly available, such as where people schedule care, checkin for appointments, or pay bills. Not required if there is no publicly accessible location.	Must appear on a searchable public website of the provider or facility. Not required if the provider or facility does not have its own website.	• Must be provided inperson, by mail, or email, as selected by the individual, to individuals who have health insurance coverage subject to the No Surprises Act. • Must be provided by the time payment is requested. • If no payment is requested, the notice must be provided by the time a claim is submitted to the consumer's health plan.
Health plans, issuers of group or individual health insurance coverage, FEHB carriers	Generally publicly available	Must be posted on a public website of the plan/issuer/ FEHB carrier	Must be included on each explanation of benefits for items or services subject to the No Surprises Act

This document is intended to provide clarity to the public about requirements related to surprise billing. It does not have the force and effect of law.

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Federal Civil Rights Laws

For entities that receive federal financial assistance, the notice must comply with applicable federal civil rights laws that prohibit discrimination, which require covered entities to:

- Take reasonable steps to ensure meaningful access to individuals with limited English proficiency, which may include offering language assistance services such as translation of written content into languages other than English; and
- Take appropriate steps to ensure effective communication with individuals with disabilities, including provision of appropriate auxiliary aids and services.

For more information, see the model disclosure notice instructions.

Below is an example of what the notice might look like. Providers, facilities, health plans, health insurance issuers, and FEHB carriers are not required to use this example, but the notice must comply with the requirements described in the model disclosure notice instructions.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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, like a copayment, coinsurance, or deductible. You may have additional 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" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays 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 plan's deductible or 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're 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 they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). 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.

[*Summary of any applicable state billing laws or requirements or state-developed language*]

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 can 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.

The notice must explain surprise billing protections under the No Surprises Act. It must also explain any state laws that provide surprise billing protections.

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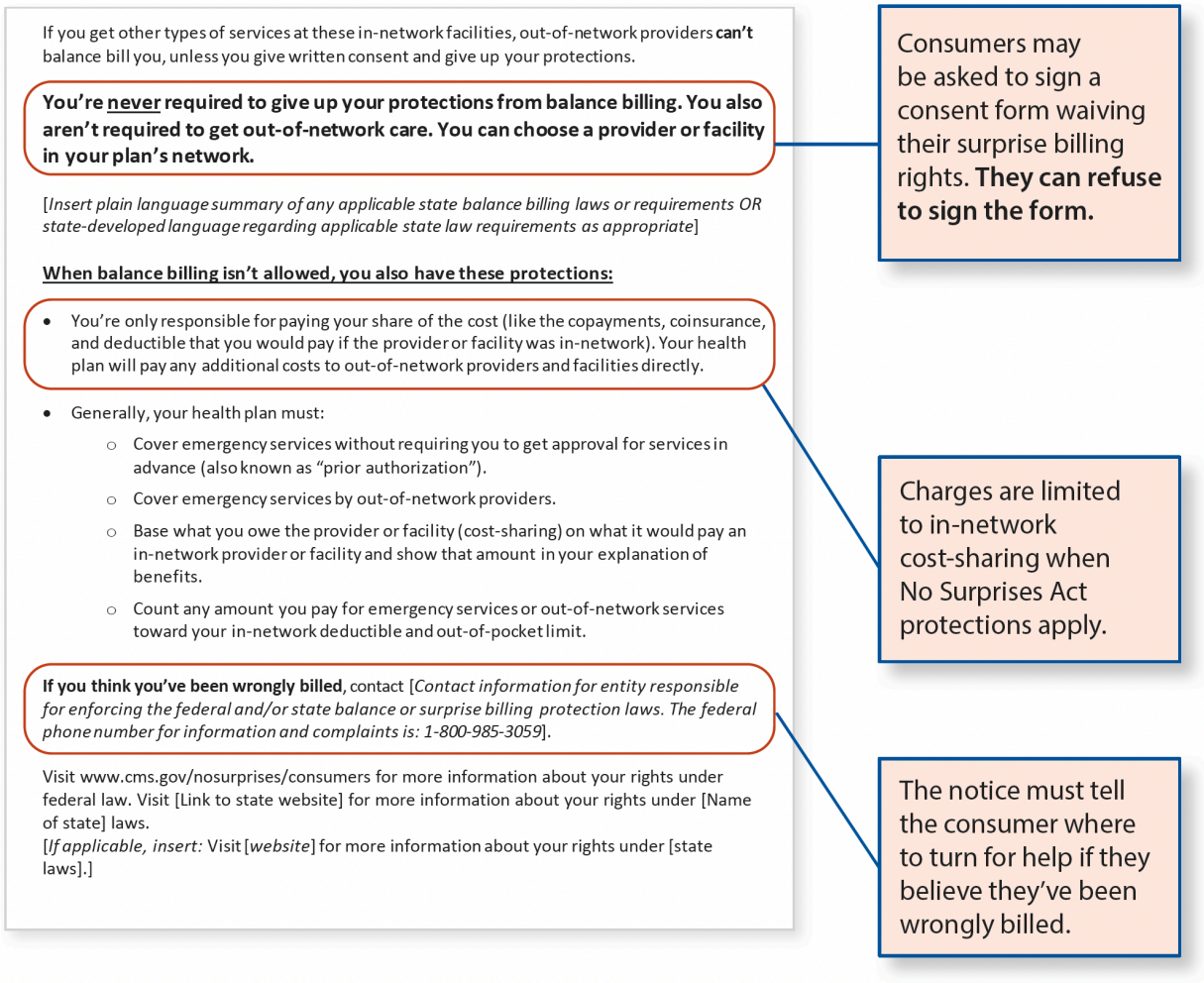

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed language regarding applicable state law requirements as appropriate*]

<u>When balance billing isn't allowed, you also have these protections:</u>

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "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 in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact [*Contact information for entity responsible for enforcing the federal and/or state balance or surprise billing protection laws. The federal phone number for information and complaints is: 1-800-985-3059*].

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law. Visit [Link to state website] for more information about your rights under [Name of state] laws.
[*If applicable, insert:* Visit [*website*] for more information about your rights under [state laws].]

Consumers may be asked to sign a consent form waiving their surprise billing rights. **They can refuse to sign the form.**

Charges are limited to in-network cost-sharing when No Surprises Act protections apply.

The notice must tell the consumer where to turn for help if they believe they've been wrongly billed.

NOTE: The Department of Health and Human Services created two versions of the sample notice. The initial version, published under emergency approval from the Office of Management and Budget, was allowed for use in 2022 only. A revised, second version is for use in 2022 and beyond. The second version is pictured above.

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