EASTERN OKLAHOMA
EAR, NOSE & THROAT, Inc.

# PATIENT RIGHTS AND PROTECTION AGAINST SURPRISE MEDICAL BILLS

Patient Name: _____

Account #: _____

When you get emergency care or are treated by an out-of-network provider at an in-network hospital, you are protected from balance billing. In these cases, you should not be charged more than your plan's copayments, coinsurance 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 be required 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" refers to 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, and they 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 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). You CANNOT 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 balance billed for these post-stabilization services.
- **Certain services at an in-network hospital or ambulatory surgical center**
  When you get services from an in-network hospital or ambulatory surgery center, certain providers associated therewith 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.
  If you receive other services at an in-network facility, out-of-network providers CANNOT balance bill you and may NOT ask you to give up your protection not to be balanced billed.
  You are never required to give up your protections from balance billing. You also are not required to get your care out-of-network. You can choose a provider or facility in your plan's network to avoid balance billing.

## 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 pay if the provider was in-network.

**Your health plan generally must:**

- Cover emergency services without requiring you to get approval 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 (EOB).
- 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 believe you have been wrongfully billed, you may contact the Oklahoma Insurance Department at 400 NE 50th St., Oklahoma City, OK 73105 or 1-800-522-0071 or The Centers for Medicare and Medicaid at the NO SURPRISES HELP DESK at 1-800-985-3059.**

**Visit https://www.cms.gov/nosurprises for more information about your rights under the law.**

*Select Relationship to Patient Before Signing:*

☐ Patient ☐ Parent ☐ Guardian ☐ Other (please specify) _____

By signing below, you represent that you are either the patient or a representative of the patient with authority to sign for the patient.

Signature _____ Date _____