YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

"**Surprise Medical Bills**" or "**Balance Billing**" may arise when you get care from a provider or health care facility that has not signed a contract with your health insurance plan to provide those services (also known as "out-of-network").

When you seek medical services that are out-of-network, you may owe a copayment, and/or coinsurance, and/or deductible, depending on your health insurance plan benefits. Your health plan will determine what an acceptable amount is for those out-of-network services (insurance payment + copayment + coinsurance + deductible). Out-of-network providers and health care facilities may have billed you for the difference in what your health plan determined as an acceptable amount and the total charges on your account. This is called **balance billing**.

Surprise billing is an unexpected balance bill. This can happen when you cannot control who is involved in your care and you unexpectedly receive a bill for that care.

When you get emergency care or are treated by an out-of-network provider at an in-network hospital, **you are now protected from balance billing and surprise medical bills as of January 1, 2022.**

Federal Protections for Emergency Services and Certain Services at an in-network hospital:

- If you have an emergency medical condition and get care from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount. This includes services you may get after you're in stable condition unless you provide written consent and give up these protections.
- When you get services at an in-network hospital, certain providers may be out-of-network. The most these providers can bill you is your plan's in-network cost share amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to agree to be balanced billed.
- Generally, your health plan must cover out-of-network emergency services at an in-network rate without requiring advance approval (prior authorization). You're only responsible for paying your share of cost (copayment, coinsurance, deductible) that you would pay if the provider or facility was in-network, and these amounts are applied to your in-network benefits and out-of-pocket limits.
- **YOU ARE NEVER REQUIRED TO GIVE UP YOUR PROTECTIONS FROM BALANCE BILLING**

State Protections

As of January 1, 2020, Assembly Bill 439 (439B.700 – 439B.760) protects patients from being balance billed for medically necessary emergency services provided by an out-of-network provider if covered by the following type(s) of insurance plan:

- health benefit plans regulated by the state,
- the Public Employee's Benefits Program,
- large group plans regulated by the federal government that opt into Nevada's balance billing legislation

In addition, any providers that are not contracted with your network can only hold you responsible for the copayment, coinsurance or deductible required for such medically necessary emergency services provided by an in-network provider.

If you think you have been wrongly billed:

While it is never our intention to balance bill our patients, if you believe that this may have happened to you, please contact one of our Customer Service team members at 877.516.0911, Option 1, to review your account. If we fail to address your concern, you may contact The Department of Business and Industry, Nevada Division of Insurance at 888.872.3234 or visit https://doi.nv.gov/Consumers/Health_and_Accident_Insurance/Balance_Billing_FAQs/ for more information about your rights under Nevada law, OR with the Federal No Surprises Helpdesk at 1.800.985.3059 or online at www.cms.gov/nosurprises.

Dignity Health.
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