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THE NO SURPRISES ACT:
YOUR RIGHTS AND PROTECTIONS AGAINST SRUPRISE MEDICAL BILLS

STANDARD NOTICE AND CONSENT DOCUMENTS

(OMB Control Number: 0938-1401)

I am a preferred provider for AETNA, Blue Cross Blue Shield, Medicare and Pacific Source.
I am an out-of-network provider for the other plans, like Providence, UBC, Magellan, Moda.

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, like a psychologist like me, you may owe certain out-of-pocket costs, such as copayment, coinsurance, and/or deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. If I am an out-of-network provider for your plan, I am permitted to bill you for the difference between what your plan agreed to pay in-network providers and the full amount I charge for the service. This is called "**balance billing."** This amount is likely and usually higher than in-network costs for the same service by an in-network provider and your plan might not count it toward your annual out-of-pocket limit, especially, if you do not have out-of-network coverage. Some plans allow for out-of-network services, but often have a higher or separate deductible and will only apply their allowable costs against your unmet deductible, not what your costs are to see me.

"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.

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 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.

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 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. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other 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 are never required to give up your protection from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in 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 copayments, coinsurance, and deductibles that you would pay if the provider or facility were in-network.). Your health plan will pay out-of-network providers and facilities directly.

- **Please verify with you plan**. Your health plan generally must:
  Cover emergency services without requiring you to get approval for services 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.

- Count any amount you pay for emergency services or out-of-pocket network services toward your deductible and out-of-pocket limit.

If you believe you have been wrongly billed, please address your concern with me so we can resolve your concern. You may also contact OR Division of Financial Regulation or the Oregon Board of Psychologist Examiners.

Visit: https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf
for more information about your rights under Federal law. If applicable to your state: Visit dcbs.oregon.gov for more information about your rights under Oregon laws

You **shouldn't** sign the consent form if you **didn't** have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change. Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one.