

NORTH OGDEN SURGERY CENTER

NO SURPRISE ACT

The organization will advise all patients of their rights regarding the Federal No Surprises Act enacted January 1, 2022.

Patients may be given the following information in the form of a handout at the time of registration. Patients will be referred to the Administrator if they have any questions.

No Surprises Act: Billing Disclosures

Effective January 1, 2022, the federal No Surprises Act protects patients from surprise bills for emergency services and for certain non-emergency services provided by out-of-network providers at in-network facilities. If these protections apply, patients are only liable for in-network cost-sharing amounts.

Your Rights and Protections Against Surprise Medical Bills

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 health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, or a deductible. You may also have other costs or have to pay the full 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 a provider or facility hasn't signed a contract with your health plan. Out-of-network providers may be allowed to bill you for the difference in your plan's benefits and the full cost of a service. This is balance billing. A balance bill is likely more than your in-network costs for a service and may not apply to your annual out-of-pocket limit.

A surprise bill 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 get emergency services from an out-of-network provider or facility, the provider or facility may not bill you more than your plan's in-network cost-sharing amount (such as copayments and coinsurance). They can't balance bill you 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 surgical center, some 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're never required to give up your protections 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.

No Surprises Act: Billing Disclosure Attestation

Effective January 1, 2022, the federal No Surprises Act protects patients from surprise bills for emergency services and for certain non-emergency services provided by out-of-network providers at in-network facilities. If these protections apply, patients are only liable for in-network cost-sharing amounts.

Your Rights and Protections Against Surprise Medical Bills

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 health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, or a deductible. You may also have other costs or have to pay the full 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 a provider or facility hasn't signed a contract with your health plan. Out-of-network providers may be allowed to bill you for the difference in your plan's benefits and the full cost of a service. This is balance billing. A balance bill is likely more than your in-network costs for a service and may not apply to your annual out-of-pocket limit.

A surprise bill 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 get emergency services from an out-of-network provider or facility, the provider or facility may not bill you more than your plan's in-network cost-sharing amount (such as copayments and coinsurance). They can't balance bill you 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 surgical center, some 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're never required to give up your protections 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.

Signature (Patient)Date

Signature (Witness)Date