

Effective January 1, 2022, the No Surprises Act, which Congress passed as part of the Consolidated Appropriations Act of 2021, is designed to protect patients from surprise bills for emergency services at out-of-network facilities or for out-of-network providers at in-network facilities, holding them liable only for in-network cost-sharing amounts. The No Surprises Act also enables uninsured patients to receive a good faith estimate of the cost of care.

### **Billing Disclosures – 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 doctor or other healthcare provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have different costs or have to pay the entire bill if you see a provider or visit a healthcare facility that isn’t in your health plan’s network.

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay 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 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.

#### **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 balance billed for these post-stabilization services.

Additionally, Nevada law protects patients covered by health benefit plans regulated by the state, the Public Employees Benefits Program, and third parties that opt into the prohibition on balance billing for medically necessary emergency services provided by an out-of-network provider.

#### **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'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.**

Additionally, Nevada law requires that the patient pay only their in-network cost-sharing amounts. This law does not apply to (1) any patient who has coverage through an out-of-state insurance policy, (2) critical access hospitals or any medically necessary emergency services provided at such a hospital, and (3) any out-of-network healthcare services provided 24 hours after notification that a patient has been stabilized.

**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 was in-network). Your health plan will pay out-of-network providers and facilities directly.
- 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-network services toward your deductible and out-of-pocket limit.

### **Provider Information**

We are committed to transparency and compliance with the No Surprises Act. Below is the credential information for our Clinic Director:

Dr. Peter Dickinson/Dickinson Chiropractic, LLC  
National Provider Identifier (NPI) personal: 1912200866

National Provider Identifier (NPI) Group: 1083338206  
License Number: 1568

**Contact Information**

If you have questions about the No Surprises Act, billing practices, or your rights, please contact us:

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