PGH
PERSHING
GENERAL
HOSPITAL
&
Nursing Home

OMB Control Number: 0938-1401

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you should not be charged more than your plan's copayments, coinsurance and/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, 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" means providers and facilities that have not 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. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and 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 cannot 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 they can bill you is your plan's in-network cost sharing amount (such as copayments, coinsurance, and deductibles). You **cannot** be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Pursuant to Nevada Revised Statute (NRS) 439B.410, hospitals are obligated to provide emergency services and care to patients regardless of the financial status of the patient.

NRS 439B.745 prohibits out-of-network providers from collecting any amount that exceeds the copayment, coinsurance, or deductible required for the same services provided by an in-network provider. The patient's condition must be stabilized before transferred to an in-network emergency facility.

NRS 439B.748 and 439B.751, permit the billing of medically necessary emergency services for a covered person to an out-of-network provider, if the out-of-network provider was contracted for services with the facility within specific timelines. Applicable percentage reimbursement rates apply according to contract terms.

PGH
PERSHING
GENERAL
HOSPITAL
&
Nursing Home

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 can 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 **cannot** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you also have these protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility were in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "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 in-network deductible and out-of-pocket limit.

Nevada Revised Statue 232.462 has established the Bureau of Hospital Patients within the Office for Consumer Health Assistance to resolve, mediate, and arbitrate disputes between patients and hospitals. Patients may contact the Bureau for a resolution concerning the accuracy and amounts billed by the hospital and for assessment of the reasonableness of payment arrangements made.
If you think you have been wrongly billed, contact Pershing General Hospital Business office at 755-273-2621.

The federal phone number for information and complaints is 1-800-985-3059.
Visit **www.cms.gov/nosurprises/consumers** for more information about your rights under federal law.

Visit **https://mypatientrights.org/file-a-complaint/nevada/** for more information about your rights under Nevada laws.