NO SURPRISES ACT NOTICE

ONCURA HEALTH

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 shouldn't 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, such as a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire 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 providers and facilities that haven't 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 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're 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 can't be balance billed for these emergency services, including 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.

CALIFORNIA — BALANCE BILLING
Under California law (AB 72; Health & Safety Code § 1371.9 and § 1371.30), if you are enrolled in a health plan regulated by the State of California, you are protected from surprise balance bills. If you receive covered non-emergency services at an in-network facility and are treated by an out-of-network provider, you pay only your in-network cost-sharing amount. For emergency services, you can never be balance billed and can never be asked to give up this protection.

NO SURPRISES ACT NOTICE, CONTINUED

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, and 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 types of 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 out-of-network care. You can choose a provider or facility in your plan's network.

CALIFORNIA — WRITTEN CONSENT TIMING
Under California law, if you have out-of-network benefits and choose to receive non-emergency care from an out-of-network provider at an in-network facility, that provider must obtain your written consent at least 24 hours in advance, on a separate document, and give you a written estimate of your out-of-pocket cost before you agree. You may instead choose an in-network provider or contact your plan.

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THESE PROTECTIONS:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was 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 prior authorization; cover emergency services by out-of-network providers; base what you owe on what it would pay an in-network provider and show that amount in your explanation of benefits; and count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact
OneOncology Privacy Officer
ooprivacyteam@oneoncology.com
615.880.8479.

California DMHC Help Center: 1.888.466.2219
For state-regulated plans
California Department of Insurance: 1.800.927.4357
Federal No Surprises information and complaints: 1.800.985.3059