

You have the right to receive a “Good Faith Estimate” explaining how much your medical care will cost

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

In advance of their surgery, patients shall be informed of their benefits, the total price of their surgery, and any monies that will be due to the surgery center subsequent to the verification of benefits and calculation of the patient financial responsibility. Patients who have a dollar amount due from surgery, shall receive this information in writing in advance of their surgery via secure encrypted email/text or first-class mail. Patients will not receive any notification if there is an estimated patient portion of \$0, unless requested by the patient. Procedures scheduled within a window less than 7 days, shall be notified via telephone call or secure encrypted email/text and the estimate will be printed for check-in on the day of their procedure.

Only patients who are booked for a procedure are provided benefit estimates. Potential patients will be asked to contact their surgeon's office and their insurance company for an estimate of cost.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 1-800-985-3059.

Your Rights and Protections Against Surprise Medical Bills

When you receive emergency care or treatment from 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 healthcare provider, you may owe certain out-of-pocket costs, like 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 healthcare 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

- 1. 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. 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.

2. Certain services at an in-network hospital or ambulatory surgical center: When you receive 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 can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you receive 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 within your plan's network.

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 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.

If you think you've been wrongly billed, contact: 1-800-985-3059. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.