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 are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider and any other provider you choose for a Good Faith Estimate before scheduling an item or service.
- If you receive a bill that is at least $400 more than your Good FaithEstimate, you can dispute the bill.

Make sure to save a copy or picture of your Good Faith Estimate.

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

Your Rights & Protections Against Surprise Medical Bills

You are protected from surprise billing or balance billing when you receive emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center.

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 a deductible. You may have other costs or need 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 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 total 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 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**

  Suppose you have an emergency medical condition and get emergency services from an out-of-network provider or facility. In that case, 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 balanced 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, certain providers 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 protection from balance billing. You also aren't required to get care out-of-network. Instead, you can choose a provider or facility in your plan's network.

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 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 or prior authorization for services in advance.
  - 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 or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you have been wrongly billed, you may contact

- The No Surprises Help Desk operated by the US Department of Health and Human Services (HHS) at 1-800-985-3059, or visit **https://cms.gov/nosurprises** for more information about your rights under federal law.
- You can also contact your state's department of insurance for more information.