University Orthopaedic Surgery Center

NO SURPRISES ACT:
Good Faith Estimate & Balance Billing

Patients planning to "self-pay", *which includes those who don't have insurance or who are not using insurance,* **have the right to receive a "Good Faith Estimate" for medical items and services.**

GOOD FAITH ESTIMATE

You have the right to receive an estimate for the total expected cost of any non-emergency items or services when you plan to "self-pay". Just ask. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

· Make sure this is provided to you at least 1 business day before your service or item.
· If your bill is at least $400 more than your estimate, you can dispute the bill.
· Make sure to save a copy or picture of your Good Faith Estimate.

NO SURPRISE BILLING DISCLOSURE

Balanced billing provisions

Your Rights and Protections Against Surprise Medical Bills

When you receive emergency care or are 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. You may have other 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" describes providers and facilities that haven't signed a contract with your health plan and 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."

"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**
- **Certain services at an in-network hospital or ambulatory surgical center>**

When providers there are out-of-network, the most these providers may bill you is your plan's in-network cost-sharing amount and they can't balance bill you or ask you to give up your protections not to be balance billed. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services.

You're <u>never</u> 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.

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 payments, coinsurance, and deductibles that you would pay in-network).

Your health plan will pay out-of-network providers and facilities and generally must:

- Cover emergency services without requiring you to get approval 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 services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the U.S. Department of Health & Human Services (HHS) toll free at 1-877-696-6775.

Visit www.cms.gov/nosurprises for more information about your rights under federal law.