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No Surprises Act

Your Rights and Protections Against Surprise Medical Bills

Under the law, health care providers must give uninsured and self-pay patients a "Good Faith Estimate" explaining how much your medical care will cost upon request and/or prior to your scheduled appointment. In this private practice, all fees are communicated ahead of time in accordance with the No Surprises Act as they are located on my website. For more information about the No Surprises Act and your right to a Good Faith Estimate, please visit www.cms.gov/nosurprises or call 1-800-985-3059.

You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

Does it apply to in-network providers?

The No Surprises Act is a federal law that went into effect on January 1, 2022. The No Surprises Act protects patients from unexpected, high medical bills when receiving emergency care, or non-emergency care from out-of-network providers at in-network facilities. The Act limits the amount a patient can be billed for these services to their normal in-network cost-sharing amount (copays, coinsurance, and deductibles). This protects patients from balance billing, where providers bill the patient for the difference between their billed amount and the insurance's payment. Please note, I am an in-network provider in my private practice.

It applies to most types of health insurance, and protects you from unexpected out-of-network medical bills from:

- Emergency room visits
- Non-emergency care related to a visit to an in-network hospital, hospital outpatient department, or ambulatory surgical center
- Air ambulance services

Usually, if you don't have or use health insurance, providers must give you a good faith estimate of what your care will cost. You get the estimate when you schedule care in advance or if you ask for one. You may be able to dispute your bill if it's at least $400 more than the estimate.

You can submit a complaint if you believe that your facility, provider, or insurer isn't following these rules.

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, like a co-payment, 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service. **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. 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 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 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. 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, co-insurance, 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 believe you've been wrongly billed, you may contact the Pennsylvania Insurance Department at www.insurance.pa.gov/nosurprises or by phone at 1-877-881-6388 or TTY/TDD: 717-783-3898. Visit www.insurance.pa.gov/nosurprises for more information about your rights under federal and state law. You may also visit www.cms.gov/nosurprises for information from the federal government.