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YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS
(OMB Control Number: 0938-1401)

When you get emergency care or get 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.

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, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

"Out-of-network" describes providers and facilities that have not 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 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 annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can not control who is involved in your care. For example, 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
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, 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 not** be balance billed for these emergency services. This includes services you may get after you are 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 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 not** 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 not** balance bill you unless you give written consent and give up your protections.

You are never required to give up your protection from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you also have the following protections:

* You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that 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 for services in advance (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 deductible and out-of-pocket limit.

What does this mean for you?

Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to provide a good faith estimate of expected charges for items and services to individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing, upon request or at the time of scheduling health care items and services.
Please refer to the Practice Policy on the website for Good Faith Estimate (GFE) rendered by Jose G. Bejarano., MD. for services to be rendered in the next calendar year in accordance with the No Surprises Act. All services are listed under the section "Professional Fees".

Dr. B Psychiatry Consult, PC is not paneled with any insurance panels and is private pay only.

All services are the financial responsibility of the patient If actual billed charges substantially exceed the expected charges included in the good faith estimate, you may contact the office to let them know the billed charges are higher than the Good Faith Estimate and to discuss additional options.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days of the date on the original bill.
There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider of facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurpises or call 1-800-985-3059.
For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurpises or call 1-800-985-3059.