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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 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 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'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

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'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 balance billed for these post-stabilization services.

Additionally, Indiana law protects patients from balance billing for non-emergency services provided by out-of-network providers at in-network facilities. This protection does not apply if a patient has received advanced notice from an out-of-network provider and consents to the pricing of the healthcare services. This protection limits the financial liability of patients to the rate paid to the out-of-network provider by the covered individual's network plan plus any in-network cost-sharing amounts. This prohibition applies to all patients with coverage through a network plan.

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'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. You can choose a provider or facility in your plan's network.

Additionally, Indiana also protects patients with coverage through an HMO from balance billing for: emergency services received from an out-of-network provider or at an out-of-network facility and any covered services performed by an out-of-network provider when the covered service is not available through in-network providers, provided the patient has a referral. Indiana law requires the patient to pay only in-network expenses.

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 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.

If you believe you've been wrongly billed, you may contact:

- The U.S. Centers for Medicare & Medicaid Services (CMS) at **1-800-MEDICARE** (1-800-633-4227) or visit <https://www.cms.gov/nosurprises> for more information about your rights under federal law.
- The Indiana Department of Insurance at 800-622-4461 or 317-232-2395 or email consumerservices@idoi.in.gov.

Visit <https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf> for more information about your rights under Federal law.

Good Faith Estimate

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

Under the law, healthcare 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.

- 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 healthcare provider gives you a Good Faith Estimate in writing at least one business day before your medical service or item. You can also ask your healthcare provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

Get More Information

For questions or more information about your right to a Good Faith Estimate, visit [cms.gov/nosurprises](https://www.cms.gov/nosurprises) or call **1-800-MEDICARE** (1-800-633-4227).

Office Fee’s for services

90785	Interactive complexity add on intake	\$15
99214	CONSULT	\$25.00
90791	Telehealth intake, 90 min	\$150.00
90834	Telehealth individual session, 45 min	\$80.00
90832	Telehealth individual session, 30 min	\$55.00
90837	Telehealth individual session, 60 min	\$110.00
90846	Telehealth family/Couple without client	\$110.00
90847	Telehealth family/Couple with client	\$110.00
90791	Office based intake	\$180.00
90834	Office based Individual session, 45 min	\$100.00
90837	Office based individual session, 60 min	\$125.00
90837	Crisis Session first 60 min	\$110.00
90846	Office based family/Couple without client	\$140.00
90847	Office based family/Couple with client	\$140.00