

SELF-PAY PATIENTS:

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 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, anesthesia, equipment, supplies and facility 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 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.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

Your Rights and Protections Against Surprise Medical Bills

When you receive emergency care or treatment 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” (aka “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as 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 included in your health insurance plan’s network.

“Out-of-Network” describes providers and facilities that haven’t signed a contract with your health insurance 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 such as 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 **cannot** 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.

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 insurance 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 **cannot** 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 **cannot** 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 care out-of-network. You can choose a provider or facility in your insurance 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 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.

Please note that Treasure Valley Eye Center is an in-network provider for most insurance plans. Please call the Billing Manager at (208) 288-2020 if you have questions regarding our participation with your insurance.

If you believe you've been wrongly billed, you may contact the Billing Manager at Treasure Valley Eye Center with questions at (208) 288-2020.

For more information about your rights under federal law, call 1-800-985-3059 or visit <https://www.cms.gov/nosurprises/consumers>