*Your Rights and Protections Against Surprise Medical Bills*

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 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’t balance bill you and may not ask you to giveup 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.

**Additional Balance Billing Protections**

If an out-of-network provider wants your written consent to be balance billed, the provider must give you a notice before the services are provided. The amount of advance notice required depends on the situation. In some situations, the notice must be provided at least 5 days in advance. The notice needs to include a summary of your balance billing rights, a good faith estimate of the charges for the services, and information about the provider’s obligation to explain charges that exceed the good faith estimate.

Indiana has special balance billing protections for patients with coverage through a Health Maintenance Organization (HMO). HMO patients generally pay only in-network expenses for (a) covered emergency services from an out-of-network provider or facility, (b) covered services from an in-network facility and (c) covered services from an out-of-network provider when an in-network provider is not available, if the patient has a referral.

**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 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 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 Indiana Department of Insurance at 1-317-232-8582 or visit <https://www.in.gov/idoi>
* The US Centers for Medicare & Medicaid Services (CMS)
* No Surprises Health Desk at 1-800-985-3059
* Or visit <https://www.cms.gov/nosurprises> for more information about your rights under federal law.

IF YOU PREFER TO GET A COPY OF THIS NOTICE IN-PERSON, BY US MAIL OR BY ELECTRONIC MAIL, PLEASE NOTIFY THE FRONT OFFICE OR BILLING STAFF OF YOUR PREFERENCE.

[Print PDF file here](https://www.urologyin.com/sites/default/files/imce/docs/Balance%20Billing%20Notice%20UOI%2012202021.pdf)

**Balance Billing Notice 12202021**

*Your Rights to a Good Faith Estimate*

You have the right to receive a “Good Faith Estimate” explaining how much your medical care will cost. Both federal and state laws give patients rights to Good Faith Estimates of the bill for non-emergency health care items and services.

**Rights under Federal 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 health care provider gives you a Good Faith Estimate in writing at least 1 business day before your scheduled medical item or service.
* You also can ask your health care provider, and any other provider your 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.

**Rights under State Law**

Healthcare providers need to give an estimate of the bill for medical items and services to all patients who request an estimate.

* Any patient (insured, uninsured, or self-pay) may request a Good Faith Estimate of expected charges for non-emergency health care items and services.
* When an estimate is requested, you will be provided a written copy of a Good Faith estimate within 3 business days of the request (when uninsured or self-pay) and within 5 business days of the request (when insured).

**For questions or more information about your rights to a Good Faith Estimate:**

* Visit [www.cms.gov/nosurprises/consumers](http://www.cms.gov/nosurprises/consumers) or call 1-800-985-3059; or
* Visit [www.in.gov/idoi](http://www.in.gov/idoi) or call 1-800-622-4461

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**Good Faith Estimate Notice 12202021**