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HARTFORD ORTHOPEDIC MEDICINE

As of January 1, 2022, under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to inform 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 of their ability, upon request or at the time of scheduling health care items and services, to receive a "Good Faith Estimate" of expected charges.

Under the "No Surprises Act", 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. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises The following pages will help further explain your rights under the recently-enacted "No Surprises Act"

Notification of a Patient's Right to Receive a Good Faith Estimate Detailing How Much Medical Care Will Cost

For patients with no insurance or those who opt not to use their insurance, healthcare providers must give an estimate of the expected bill for medical services and items.

What the patient should know:

- A patient with no insurance or a patient opting not to use their insurance has the right to receive a Good Faith Estimate for any non-emergency services or items.
- If you believe you are eligible for a Good Faith Estimate, be sure your healthcare provider gives you one in writing at least 1 business day before you are scheduled to receive the service(s) and/or item(s). 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.
- Be sure to save a copy or picture of your Good Faith Estimate.
- Following your service or receipt of an item, if you get a bill that is **at least $400.00 more than your Good Faith Estimate**, you can dispute the bill through the U.S. Department of Health and Human Services. There is a fee to dispute the bill.

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

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 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 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 health plan agreed to pay and the full amount charged for a service.
- "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.

- **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 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 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 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 No Surprises Help Desk at 1-800-985-3059 and/or file a complaint with the Connecticut State Bureau of Insurance at 1-800-203-3447 or 860-297-3900.

Visit **cms.gov/nosurprises** for more information about your rights under federal law.