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

When you get services from an in-network hospital, 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 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 third-party arbitrator listed via the website link below.

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

Lakeland Community Hospital
Good Faith Estimate of what you could pay

Patient Name: _____
Out-of-network provider(s) or Facility Name: _____
_____

Total cost estimate of what you may be asked to pay:

Date of Service	Service Code	Description	Amount Billed

- **Call your health plan.** Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan and your provider options
- **Questions about this notice and estimate?** Call Admitting @ (205) 486-7214
- **Questions about your right?** Visit https://www.cms.gov/nosurprises

Prior Authorization or other care management limitations

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care

With my signature, I am saying that I agree to get the items or services from Lakeland Community Hospital and associated physicians

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services, or have to pay out-of-network cost-sharing under my health plan
- I was given written notice on _____explaining that my provider of facility isn't in my health plan's network, estimated cost of services, and what I may owe if I agree to be treated at this provider or facility
- I got the notice either on paper or electronically, consistent with my choice
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out of pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services

IMPORTANT: You **don't** have to sign this form. But if you don't sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan's network.

_____ or _____
Patient's Signature | Guardian/authorized representative's signature

_____ _____
Print Name of Patient | Print name of Guardian/authorized representative

_____ _____
Date and time of signature | Date and time of signature

Take a picture and/or keep a copy of this form.
It contains importation information about your rights and protections.