Tower Urology

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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, like a copayment, coinsurance, or deductible. You may have additional 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" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays 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 plan's deductible or 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're 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 they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance and deductibles). 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.

Please see below for information regarding California law.

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 can 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 types of 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 out-of-network care. You can choose a provider or facility in your plan's network.

Please see below for information regarding California law.

When Balance Billing Isn't Allowed, You Also Have These Protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "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 in-network deductible and out-of-pocket limit.

California Law: California law generally contains balance billing protections similar to those under the No Surprises Act (as described in this Notice), except that the balance billing prohibitions also apply to services received in additional in-network facilities, including laboratories or radiology imaging centers. California also has an independent dispute resolution process to resolve claims-related issues, including disputes with your provider pertaining to receipt of improper balance bills, which can be initiated through the California Department of Insurance.

If you think you've been wrongly billed, contact the HHS No Surprises Helpdesk at **1-800-985-3059**, which is the entity responsible for enforcing the federal balance or surprise billing protection laws.
Visit **www.cms.gov/nosurprises/consumers** for more information about your rights under federal law.

For more information about your rights under California law, including how to initiate the dispute resolution process, contact the Department of Insurance Help Center, which is the entity responsible for enforcing state balance or surprise billing protection laws, online at **www.insurance.ca.gov/01-consumers/101-help/index.cfm** or by calling **1-800-927-4357**.

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, prescription drugs, equipment and hospital fees.

- Make sure your health care provider gives you a Good Faith Estimate in writing:
    - When your medical service or item is scheduled at least three business days in advance: Not later than one business day after the date of scheduling.
    - When your medical service or item is scheduled at least 10 business days in advance: Not later than three business days after the date of scheduling.
- 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, and they must provide it no later than three business days after your request.
- 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 any additional questions, or more information about your right to a Good Faith Estimate, visit **www.cms.gov/nosurprises** or call 1-**800-985-3059**