INFIRMARY HEALTH

NO SURPRISES ACT NOTICE

WHAT IS "BALANCE BILLING" OR "SURPRISE BILLING?"

When you see a doctor or other healthcare 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 hospital or ambulatory surgery center (health care facility) that is not 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 your cost-sharing responsibilities and the full amount charged for a service. This amount is called "balance billing" and 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 for example: 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 in the following situations:

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 collect from you is your plan's in-network cost-sharing amount (such as co-payments and coinsurance). You can't be balanced billed for the difference between 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 certain services other than emergency 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 hospital-based providers: 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 (such as surgeons and other non-hospital-based providers) can't balance bill you, unless you give written consent and give up your protections.
You're never required to give up your protection 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 under the act, what can I do?

You are only responsible for paying your cost-share responsibility (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 (prior authorization) for services in advance.
- 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 in-network 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 Infirmary Medical Clinics Billing Department at 251-435-3300. Visit Center for Medicare and Medicaid services at www.cms.gov/nosurprises for more information about your rights under federal law.

Your Right To a "Good Faith Estimate" for Non-Emergency Services

You have the right to receive a "Good Faith Estimate" explaining how much your non-emergency medical care may cost. Under the law, health care providers need to give patients who do not have insurance, or who are not using insurance, a cost estimate of the bill for non-emergency 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, drugs, equipment, and hospital fees.
- Your health care provider must give you a "Good Faith Estimate" in writing for scheduled services at least one business day before your medical services if scheduled at least three days in advance. You can ask your health care provider 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 you save a copy of your Good Faith Estimate.