First Urology, PSC

Good Faith Estimate:
Rights and Protections Against Surprise Medical Bills

Thank you for choosing First Urology, PSC for your health care needs. The Good Faith Estimate: Rights and Protections Against Surprise Medical Bills was created to ensure patients are well-informed regarding the cost of medical services.

What is "balance billing" (sometimes called "surprise billing")?

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.

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, 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 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:
https://www.cms.gov/nosurprises/consumer-protections/Payment-disagreements

For more information about your rights under federal law, visit:
https://www.cms.gov/nosurprises

Good Faith Estimate

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost.

Under state and federal law, a patient may ask a health care provider for a Good Faith Estimate of the price the health care provider and health facility will charge for providing a nonemergency health care service, including costs such as medical tests, prescription drugs, equipment, and hospital fees. The Good Faith Estimate will be made in writing and provided within the timeframes stated in this notice.

- **Any patient**. Any patient (insured, uninsured, or self-pay) may request a Good Faith Estimate of expected charges for nonemergency health care services. When one is requested, you will be provided a copy of this Good Faith Estimate within 3 business days of the request (when uninsured or self-pay) and 5 business days (when insured).
- **Uninsured Patients**. Federal law requires health care providers to give you a Good Faith Estimate in advance of scheduling or upon request if you are uninsured or self-pay (not using your insurance to pay for the item or service). The Good Faith Estimate will be provided within 3 business days of scheduling the nonemergency health care service or within 1 business day if the nonemergency health care service is scheduled to be performed by the practitioner within 3 business days.

You may ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.

Patients who are uninsured or self-pay may dispute the actual charges if they exceed the Good Faith Estimate by at least $400.00.

Make sure to save a copy of your Good Faith Estimate.

Get More Information

For questions or more information about your right to a Good Faith Estimate,
visit cms.gov/nonsurprises or call 1-800-MEDICARE (1-800-633-4227).