TAMPA BAY SURGICAL GROUP

As of January 1, 2022, patients have a right to an estimate of the cost of services they will receive during a procedure or surgery, called a Good Faith Estimate, and protection from unexpected or surprise bills when they receive care from out-of-network providers at in-network facilities. These protections are part of the Consolidated Appropriations Act of 2021 which includes the No Surprises Act.

Good Faith Estimate

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

Under the law, health care providers are 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 at least 1 business day before your medical service or item. 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.
- 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 of your Good Faith Estimate.

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

When you see a doctor or other health care provider, you may owe specified 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.

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 balanced billed for these post-stabilization services.

In general, Florida law prohibits providers from balance billing commercially insured patients for emergency services. Florida has two separate laws that protect PPO and HMO members from balance billing. You should contact your insurer to determine whether you are a PPO or HMO member. HMO Patients: A provider may not collect or attempt to collect payment from a HMO subscriber for any amount that is the responsibility of the HMO. Fla. Stat. § 641.3154. A subscriber's copayment for emergency services is limited to a reasonable copayment not to exceed $100 per claim. Fla. Stat. §§ 641.513(4), 641.31(12). PPO Patients: For emergency services provided by out-of-network providers and facilities, Florida law prohibits the provider or facility from charging PPO patients for any balance not paid by insurance. Fla. Stat. § 627.64194(5). The PPO patient's cost sharing amount is limited to the in-network amount.

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.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like 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 that are out-of-network.
  - 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.

If you think you've been wrongly billed, contact The U.S. Centers for Medicare & Medicaid Services (CMS) at 1-800-MEDICARE (1-800-633-4227) or visit **https://www.cms.gov/nosurprises**/consumers for more information about your rights under federal law.

The Florida Department of Financial Services, Division of Consumer Services at 1-877-MY-FL-CFO.

*The federal phone number for information and complaints is: **1-800-985-3059**.*