PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

Heartfelt Pediatrics LLC is committed to helping you navigate issues and concerns that impact your physical and financial health. The No Surprises Act is a federal law that impacts health care billing and protects you from certain surprise medical bills. The No Surprises Act requires this disclosure to explain your rights and protections under the federal requirements. For example, 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 medical billing or balance billing. In these cases, you should not be charged more than your plan's copayments, coinsurance, or deductible.

Explaining Surprise Medical Billing and Balance Billing

When you see a doctor or other health care provider, you may owe certain out-of-network amounts, such as a copayment, coinsurance, or deductible. You may also have other costs or have to pay the entire bill if the provider you see or the health care facility that you visit does not participate in your health plan's network (an "out-of-network" provider or facility).

- **What is out-of-network?** Out-of-network describes health care providers and facilities that have not signed a contract with your health plan. Out-of-network providers or facilities may be permitted to bill you for the difference between what your health plan agreed to pay the provider or facility and the full amount charged for the health care service provided to you. This is called balance billing. This amount is likely more than in-network costs for the same service and might not count towards your annual out-of-pocket limit. Surprise billing is sometimes also called balance billing.
- **What is surprise billing?** Surprise billing is an unexpected balance bill for a service provided by an out-of-network provider or facility. This can happen in situations where you cannot control who is involved in providing your care, such as in an emergency or when you schedule an appointment 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.

Surprise Billing Protections

You are protected from receiving a surprise medical bill in certain circumstances:

- **Emergency Services.** If you have an emergency medical condition and receive emergency services from an out-of-network provider or facility, the most that the provider or facility may bill you is your plan's in-network cost-sharing amount (such as a copayment, coinsurance, or deductible). You cannot be balanced billed for these emergency services. You also cannot be balanced billed for services you may get after you are in stable condition, unless you give written consent to give up your balance billing protections for these post-stabilization services.
- **Certain Services at an In-Network Hospital or Ambulatory Surgical Center.** When you receive services from an in-network hospital or an ambulatory surgery center, certain providers at the facility may be out-of-network with your health plan. In these

situations, the most those providers may bill you is your in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot 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 cannot balance bill you unless you give written consent and give up your protections.

Patient Protections

You are never required to give up your protections from balance billing. You also are not required to get care from out-of-network providers or facilities. You can always choose to receive care from a provider or facility that is in-network with your plan.

If balance billing is not allowed, you have protections, including:

- You are only responsible for paying your share of the cost, which is the copayment, coinsurance, or deductible that you would pay if the provider or facility was in-network. Your health plan is required to pay providers and facilities directly.
- Generally, your health plan must:
  - cover emergency services without requiring advance approval (prior authorization) for the services;
  - cover emergency services provided by out-of-network providers and facilities;
  - determine what you owe the provider or facility (the cost-sharing amount) on what the health plan would pay an in-network provider or facility for the service and show that amount in your explanation of benefits; and
  - count any amount you pay for emergency or out-of-network services towards your deductible and out-of-pocket limit.

Complaints and Grievances

If you believe you have been wrongly billed, you should first contact the provider or facility that sent you the bill as well as your health plan for an explanation of the charges. If they cannot resolve your concerns, you can contact the United States Department of Health and Human Services (https://www.cms.gov/nosurprises or call 1-800-985-3059) regarding potential violations of your federal protections.

For More Information

Visit https://www.heartfeltpediatrics.com or https://www.cms.gov/nosurprises/consumers for more information about your rights and protections against surprise medical billing under federal law.