Right to Receive a Good Faith Estimate

Notice required under the federal No Surprises Act (Public Health Service Act § 2799B-6)

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of their bill for health care items and services before those items or services are provided.

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.

What you can expect:

- If you schedule a service at least 3 business days in advance, your provider must give you a Good Faith Estimate in writing within 1 business day of scheduling.
- If you schedule a service at least 10 business days in advance, your provider must give you a Good Faith Estimate in writing within 3 business days of scheduling.
- You can also ask your provider, or any provider you're considering, 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 or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, or how to dispute a bill, visit www.cms.gov/nosurprises or call 1-800-985-3059.

To request a Good Faith Estimate from Minds Over Matter, contact our office at 517-343-6147 or through mindsovermattermi.com.

Your Rights and Protections Against Surprise Medical Bills

Notice required under the federal No Surprises Act

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 surprise billing, or balance billing.

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, such as a copayment, coinsurance, or deductible. You may have other 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” describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be allowed 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 they can 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, including 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.

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, and services from assistant surgeons, hospitalists, and intensivists. 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 count any amount you pay for emergency services or certain out-of-network services (described above) toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, contact the No Surprises Help Desk at 1-800-985-3059 or visit www.cms.gov/nosurprises.

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