NO SURPRISE 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 need to give **patients who don't have insurance or who are not using insurance** (paying full cost) 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 **within 3 business days of the appointment if the appointment is scheduled 10 business days in advance**. This can include related costs to services 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 if scheduling an appointment within 9 days in advance or if you requested a Good Faith Estimate without scheduling, 3 days after request. 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 or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or contact the Billing Department at: Dean Dorton Health Solutions at 502-916-3158. **For disputes**, you may request a Complaint Form from the office to start the dispute process if you feel you was charged for more than the amount given to you on the Good Faith Estimate for a service(s) that was provided to you by Triad Health Systems, Inc.

What are the new protections?

For consumers who get coverage through their employer (including a federal, state, or local government), through the Health Insurance Marketplace® or directly through an individual health plan, beginning **January 2022**, these rules will:

- Ban surprise billing for emergency services. Emergency services, even if they're provided out-of-network, must be covered at an in-network rate without requiring prior authorization.
- Ban balance billing and out-of-network cost-sharing (like out-of-network co-insurance or copayments) for emergency and certain non-emergency services. In these situations, the consumer's cost for the service cannot be higher than if these services were provided by an in-network provider, and any coinsurance or deductible must be based on in-network provider rates.
- Ban out-of-network charges and balance billing for ancillary care (like an anesthesiologist or assistant surgeon) by out-of-network providers at an in-network facility.
- Ban certain other out-of-network charges and balance billing without advance notice. Health care providers and facilities must provide consumers with a plain-language consumer notice explaining that patient consent is required to get care on an out-of-network basis before that provider can bill the consumer.

For consumers who don't have insurance, these rules make sure each individual knows how much their health care will cost before they get it, and might help if the patient receives a bill that's larger than expected. For further information on payment disputes between uninsured or self-pay consumers and providers, go to: https://www.cms.gov/nosurprises/consumers/payment-disagreements

The rules don't apply to people with coverage through programs like Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE because these programs have other protections against high medical bills.