Pinehurst Medical Clinic
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Your Rights and Protections Against Surprise Medical Bills

When you are treated by an out-of-network provider at an in-network ambulatory surgical center, you are protected from surprise billing or balance billing,

What is “balance billing” (sometimes called “surprise billing”)?
When you see a healthcare provider, you may owe certain out-of-pocket costs, such as copayment, coinsurances, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a facility that is not in your insurance plan’s network.

“Out-of-network” describes providers and facilities that have not 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 procedure 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 when you have a procedure at an in-network ambulatory surgery center, which includes contracted services, such as anesthesia. If you receive out-of-network services at an in-network facility, you will only be charged the in-network amount. If you receive services at in-network facilities, out-of-network providers cannot balance bill you unless you give written consent and give up your protections. You are never required to give up your protection from balance billing. You also are not 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 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 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 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 the Manager at 910-235-3341.

Visit www.cms.gov/nosurprises for more information about your rights under federal law.

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You have the right to receive a “Good Faith Estimate” explaining how much your health care will cost.

Under the law, health care providers need to give **patients who don’t have certain types of health care coverage or who are not using certain types of health care coverage** an estimate of their bill for health care services before those services are provided.

You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This shows the cost of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur.

If you schedule a procedure at least 3 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 1 business day after scheduling. If you schedule a procedure at least 10 days in advance, make sure your health care facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can ask any health care provider or facility for a Good Faith Estimate before you schedule a procedure. If you do, make sure the facility gives you a Good Faith Estimate in writing within 3 business days after you ask.

If you receive a bill that is at least $400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.

Make sure to save a copy or picture of your Good Faith Estimate and the bill.

If you believe you’ve been wrongly billed, you may contact the Manager at 910-235-3341. You may also start a dispute resolution process with the U.S. Department of Health and Human Services. If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days of the date on the original bill.

If you dispute your bill, the facility cannot move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, the provider must cease collection efforts.

For questions, to learn more, or to get a form to start the dispute process, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.