

FEDERAL NO-SURPRISE BILLING ACT SUMMARY AND TOOL KIT

What Is the No-Surprise Billing Act

Federal law: Title I (No Surprises Act) of Division BB of the Consolidated Appropriations Act, 2021 (CAA) amended title XXVII of the Public Health Service Act (PHS Act) to add a new Part E. Part E creates **requirements such as cost sharing rules, prohibitions on balance billing for certain items and services, notice and consent requirements, and requirements related to disclosures about balance billing protections** that apply to certain providers of medical items and services (including ASCs).

NOTE: STATE SPECIFIC NO SURPRISE BILLING LAWS MAY ALSO APPLY.

What and Who does it apply to

- Applies to **all items and services** provided by certain providers (**including ASCs**) to individuals enrolled in group health plans or group or individual health insurance coverage, and Federal Employees Health Benefit plans.
- The **good faith estimate** requirement and the requirements related to the patient-provider dispute resolution process also apply to **self-pay and uninsured**.
- These requirements **do not** apply to beneficiaries or enrollees in federal programs such as Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE.

Effective Date

January 1, 2022

Summary of Rule (As Applicable to ASCs)

- **No balance billing** for non-emergency services **by nonparticipating providers** at certain participating health care facilities, **unless notice and consent** was given in some circumstances (PHSA 2799B-2; 45 CFR 149.420)
- Disclose patient protections against **balance billing** (PHSA 2799B-3; 45 CFR 149.430)
- Provide **good faith estimate in advance of scheduled services**, or upon request (PHSA 2799B-6; 45 CFR 149.610 (**for uninsured or self-pay individuals**))
- Ensure **continuity of care** when a provider's network status changes (PHSA 2799B-8)
- Improve **provider directories** and reimburse enrollees for **errors** (PHSA 2799B-9)

Balance Billing Summary

Nonparticipating providers of non-emergency services at a participating health care facility:

- **Cannot bill or hold liable** beneficiaries, enrollees or participants in group health plans or group or individual health insurance coverage who received non-emergency services by a nonparticipating provider for a payment amount greater than the in-network cost-sharing requirement for such services, **unless notice and consent requirements are met**.
 - Cost-sharing is calculated as if the total amount that would have been charged by a participating provider or participating facility were equal to the recognized amount.
 - **Notice and consent requirements do not apply** to ancillary services, for which the prohibition against balance billing remains applicable: Items and services related to emergency medicine, anesthesiology, pathology, radiology and neonatology; Items and services provided by assistant surgeons, hospitalists, and intensivists; Diagnostic services, including radiology and laboratory services; and Items and services provided by a nonparticipating provider if there is no participating provider who can provide such item or service at such facility.

ASC Applicable Disclosure Requirement

What: Balance **billing protections** and **how to report violations**.

Where: Post (1) prominently at the **location of the facility**, (2) on a **public website** (if applicable); and (3) provide it **to the participant**, beneficiary or enrollee disclose to any participant.

Good Faith Estimate

Who: **Self Pay or Uninsured Only**.

What: notification (in clear and understandable language) of the **good faith estimate** of the **expected charges, expected service, and diagnostic codes** of scheduled services – include expected charges for the items or services that are reasonably expected to be provided in conjunction with the primary item or service, including items or services that may be provided by other providers and facilities.

Continuing Care

Provider that **ends a contractual relationship with a plan or issuer, has a continuing care patient and results in change of network status must:**

- **Accept payment** for a **continuing care patient** at the previously agreed to payment amount **for up to 90 days** after the date on which the patient was notified of the change.
- **Continue to adhere to all policies**, procedures and quality standards imposed by the plan or issuer for such items or services as if the contract were still in place.

Provider Directory Improvement and Reimbursement for Errors

Must **reimburse enrollees** who relied on an **incorrect provider directory** and paid a provider bill in excess of the in-network cost-sharing amount.

To prevent **must submit provider directory information** to a plan or issuer, at a minimum:

- At the beginning of the network agreement with a plan or issuer.
- At the time of termination of a network agreement with a plan or issuer.
- When there are material changes to the content of the provider directory information of the provider or facility.
- Upon request by the plan or issuer, and
- At any other time determined appropriate by the provider, facility, or HHS.

Reference Resources

Law: <https://www.federalregister.gov/documents/2021/07/13/2021-14379/requirements-related-to-surprise-billing-part-i> and <https://www.federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-to-surprise-billing-part-ii>

CMS No Surprise Act Website:

[No Surprises Act | CMS](#)

CMS Fact Sheet:

<https://www.cms.gov/newsroom/fact-sheets/what-you-need-know-about-biden-harris-administrations-actions-prevent-surprise-billing>

FAQs:

<https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf>

Disclosure Notice Instructions and Sample for Posting (facility and website): **See Attached**

Patient Standard Notice and Consent Template: **See Attached**

(Federal No Surprise Billing Act Summary and Tool Kit – Page 2)

Note: This document is for reference purposes only and not intended as formal legal or regulatory advice. Please consult your legal and regulatory counsel for further information. Questions: contact compliance@pegisolutions.com.



CMS - Model Disclosure Notice Regarding Patient Protections
Against Surprise Billing
(See next page)

Model Disclosure Notice Regarding Patient Protections Against Surprise Billing

Instructions for Providers and Facilities

(For use beginning January 1, 2022)

Section 2799B-3 of the Public Health Service Act (PHS Act) requires health care providers and facilities to make publicly available, post on a public website of the provider or facility (if applicable), and provide a one-page notice that includes the following information in clear and understandable language:

- (1) the federal restrictions on providers and facilities regarding balance billing in certain circumstances,
- (2) any applicable state law protections against balance billing, and
- (3) information on contacting appropriate state and federal agencies if an individual believes a provider or facility has violated the restrictions against balance billing.

Health care providers and facilities can, but aren't required to, use this model notice to meet these disclosure requirements. To use this document properly, the provider or facility should review, complete, and provide it in a manner consistent with applicable state and federal law. HHS considers use of this model notice, in accordance with these instructions, to be good faith compliance with the disclosure requirements of section 2799B-3 of the PHS Act and 45 CFR 149.430, if all other applicable PHS Act requirements are met.

If a state develops model or required language for its disclosure notice that is consistent with section 2799B-3 of the PHS Act, HHS will consider a provider or facility that makes good faith use of the state-developed language compliant with the federal requirement to include information about state law protections.

Public disclosure requirements

The disclosure notice must be publicly available, and posted on a provider's or facility's website (if applicable).

- **To meet the public disclosure requirement**, providers and facilities must prominently display a sign with the required disclosure information in a location of the provider or facility (such as where individuals schedule care, check-in for appointments, or pay bills), unless the provider doesn't have a publicly accessible location.
- **To meet the separate requirement to post the disclosure on a public website**, the disclosure or a link to the disclosure must be on a searchable homepage of the provider's or facility's public website.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

Who should get this notice

In general, providers and facilities must give the disclosure notice to individuals who are:

- Participants, beneficiaries, or enrollees of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, including covered individuals in a health benefits plan under the Federal Employees Health Benefits Program, and
- To whom the provider or facility furnishes items or services, but only if such items or services are furnished at a health care facility, or in connection with a visit at a health care facility.

Providers and facilities shouldn't give these documents to an individual who has Medicare, Medicaid, or any form of coverage other than previously described, or to an individual who is uninsured.

Providing this notice

Providers and facilities must provide the notice in-person, by mail, or by email, as selected by the individual. The disclosure notice must be limited to one, double-sided page and must use a 12-point font size or larger.

Providers and facilities must issue the disclosure notice no later than the date and time they request payment from the individual (including requests for copayment or coinsurance made at the time of a visit to the provider or facility). If the provider or facility doesn't request payment from the individual, they must provide the notice no later than the date they submit a claim for payment to the plan or issuer.

Language access

Compliance with Federal Civil Rights Laws

Entities that get federal financial assistance must comply with federal civil rights laws that prohibit discrimination. These laws include section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, and section 504 of the Rehabilitation Act of 1973. Section 1557 and title VI require covered entities to take reasonable steps to ensure meaningful access to individuals with limited English proficiency, which may include offering language assistance services such as translation of written content into languages other than English.

Sections 1557 and 504 require covered entities to take appropriate steps to ensure effective communication with individuals with disabilities, including provision of appropriate auxiliary aids and services. Auxiliary aids and services may include interpreters, large print materials,

accessible information and communication technology, open and closed captioning, and other aids or services for persons who are blind or have low vision, or who are deaf or hard of hearing. Information provided through information and communication technology also must be accessible to individuals with disabilities, unless certain exceptions apply. Providers and facilities are reminded that the disclosure notice must comply with applicable state or federal language-access standards.

Use of plain language

Health care providers and facilities are encouraged to use plain language in the disclosure notice and test the notice for clarity and usability when possible.

Plain language, accessibility, and language access resources:

- [Plainlanguage.gov/guidelines](https://www.plainlanguage.gov/guidelines)
- [Section508.gov](https://www.section508.gov)
- [LEP.gov](https://www.lep.gov)

NOTE: The information provided in these instructions is intended to be only a general summary of technical legal standards. It isn't intended to take the place of the statutes, regulations, or formal policy guidance on which it is based. Refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

DON'T INCLUDE THESE INSTRUCTIONS WITH THE DISCLOSURE NOTICE GIVEN TO PATIENTS.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1401. The time required to complete this information collection is estimated to average 3.5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Instructions for Group Health Plans and Health Insurance Issuers
(For use for plan years beginning on or after January 1, 2022)

Federal law requires group health plans and health insurance issuers offering group or individual health insurance coverage to make publicly available, post on a public website of the plan or issuer, and include on each explanation of benefits for an item or service with respect to which the requirements under section 9816 of the Internal Revenue Code (the Code), section 716 of the Employee Retirement Income Security Act (ERISA), and section 2799A-1 of the Public Health Service Act (PHS Act) apply, information in plain language on:

- (1) the federal restrictions on balance billing in certain circumstances,
- (2) any applicable state law protections against balance billing,
- (3) the requirements under Code section 9816, ERISA section 716, and PHS Act section 2799A-1, and
- (4) information on contacting appropriate state and federal agencies if an individual believes a provider or facility has violated the restrictions against balance billing.¹

Plans and issuers can, but aren't required to, use this model notice to meet these disclosure requirements. To use this document properly, the plan or issuer should review, complete, and provide it in a manner consistent with applicable state and federal law. The Departments of Health and Human Services, Labor, and the Treasury (the Departments) consider use of this model notice, in accordance with these instructions, to be good faith compliance with the disclosure requirements of section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, if all other applicable requirements are met.

If a state develops model or required language for its disclosure notice that is consistent with section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, the Departments will consider a plan or issuer that makes good faith use of the state-developed language compliant with the federal requirement to include information about state law protections.

Language access

Compliance with Federal Civil Rights Laws

Entities that get federal financial assistance must comply with federal civil rights laws that prohibit discrimination. These laws include section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, and section 504 of the Rehabilitation Act of 1973. Section 1557 and title VI require covered entities to take reasonable steps to ensure meaningful access to

¹ Section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act.

individuals with limited English proficiency, which may include offering language assistance services such as translation of written content into languages other than English.

Sections 1557 and 504 require covered entities to take appropriate steps to ensure effective communication with individuals with disabilities, including provision of appropriate auxiliary aids and services. Auxiliary aids and services may include interpreters, large print materials, accessible information and communication technology, open and closed captioning, and other aids or services for persons who are blind or have low vision, or who are deaf or hard of hearing. Information provided through information and communication technology also must be accessible to individuals with disabilities, unless certain exceptions apply. Plans and issuers are reminded that the disclosure notice must comply with applicable state or federal language-access standards.

Use of Plain Language

Plans and issuers are encouraged to use plain language in the disclosure notice and test the notice for clarity and usability when possible.

Plain language, accessibility, and language access resources:

- [Plainlanguage.gov/guidelines](https://www.plainlanguage.gov/guidelines)
- [Section508.gov](https://www.section508.gov)
- [LEP.gov](https://www.lep.gov)

NOTE: The information provided in these instructions is intended to be only a general summary of technical legal standards. It isn't intended to take the place of the statutes, regulations, or formal policy guidance on which it is based. Refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

DON'T INCLUDE THESE INSTRUCTIONS WITH THE DISCLOSURE NOTICE GIVEN TO PARTICIPANTS, BENEFICIARIES, OR ENROLLEES.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1401. The time required to complete this information collection is estimated to average 3.5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain [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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

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.

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 the 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 by out-of-network providers.
 - 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, file a complaint with the Washington state Office of the Insurance Commissioner at www.insurance.wa.gov or call 1-800-562-6900. The federal phone number for information and complaints is: 1-800-985-3059.

Visit <https://www.insurance.wa.gov/what-consumers-need-know-about-surprise-or-balance-billing> for more information about your rights under.



CMS - Standard Notice and Consent Documents Under the No
Surprises Act Against Surprise Billing

(See next page)

Standard Notice and Consent Documents Under the No Surprises Act

(For use by nonparticipating providers and nonparticipating emergency facilities beginning January 1, 2022)

Instructions

The Department of Health and Human Services (HHS) developed standard notice and consent documents under section 2799B-2(d) of the Public Health Service Act (PHS Act). These documents are for use when providing items and services to participants, beneficiaries, enrollees, or covered individuals in group health plans or group or individual health insurance coverage, including Federal Employees Health Benefits (FEHB) plans by either:

- A nonparticipating provider or nonparticipating emergency facility when furnishing certain post-stabilization services, or
- A nonparticipating provider (or facility on behalf of the provider) when furnishing non-emergency services (other than ancillary services) at certain participating health care facilities.

Providers and facilities should NOT give these documents to an individual:

- Who is seeking items or services from in-network providers only,
- Who has Medicare, Medicaid, or any form of coverage other than as previously described, or
- Who is uninsured.

These documents provide the form and manner of the notice and consent documents specified by the Secretary of HHS under 45 CFR 149.410 and 149.420. HHS considers use of these documents in accordance with these instructions to be good faith compliance with the notice and consent requirements of section 2799B-2(d) of the PHS Act, provided that all other requirements are met. To the extent a state develops notice and consent documents that meet the statutory and regulatory requirements under section 2799B-2(d) of the PHS Act and 45 CFR 149.410 and 149.420 with respect to both form and manner of delivery, the state-developed documents will meet the federal specifications regarding the form and manner of the notice and consent documents.

These documents may not be modified by providers or facilities, except as indicated in brackets or as may be necessary to reflect applicable state law. To use these documents properly, the nonparticipating provider or facility must fill in any blanks that appear in brackets with the appropriate information. Providers and facilities must fill out the notice and consent documents completely and delete the bracketed italicized text before presenting the documents to patients.

In particular, providers and facilities must fill in the blanks in the “Estimate of what you could pay” section and the “More details about your total cost estimate” section before presenting the documents to patients.

The standard notice and consent documents must be given physically separate from and not attached to or incorporated into any other documents. The documents must not be hidden or included among other forms, and a representative of the provider or facility must be physically present or available by phone to explain the documents and estimates to the individual, and answer any questions, as necessary. The documents must meet applicable language access requirements, as specified in 45 CFR 149.420. The provider or facility is responsible for translating these documents or providing a qualified interpreter, as applicable, when necessary to meet those requirements. The standard notice must be provided on paper, or, when feasible, electronically, if selected by the individual or authorized representative. The individual or authorized representative must be provided with a copy of the signed consent document in-person, by mail or via email, as selected by the individual or authorized representative.

If an individual makes an appointment for the relevant items or services at least 72 hours before the date that the items and services are to be furnished, these notice and consent documents must be provided to the individual, or the individual’s authorized representative, at least 72 hours before the date that the items and services are to be furnished. If the individual makes an appointment for the relevant items or services within 72 hours of the date the items and services are to be furnished, these notice and consent documents must be provided to the individual, or the individual’s authorized representative, on the day the appointment is scheduled. In a situation where an individual is provided the notice and consent documents on the day the items or services are to be furnished, including for post-stabilization services, the documents must be provided no later than 3 hours prior to furnishing the relevant items or services.

NOTE: The information provided in these instructions is intended to be only a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance upon which it is based. Refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

DO NOT INCLUDE THESE INSTRUCTIONS WITH THE STANDARD NOTICE AND CONSENT DOCUMENTS GIVEN TO PATIENTS.

Paperwork Reduction Act Statement

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OMB Control Number: 0938-1401

Expiration Date: xx/xx/xxxx

response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Surprise Billing Protection Form

This document describes your protections against unexpected medical bills. It also asks if you'd like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider before scheduling care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility isn't in your health plan's network and is considered out-of-network. This means the provider or facility doesn't have an agreement with your plan to provide services. **Getting care from this provider or facility will likely cost you more.**

If your plan covers the item or service you're getting, federal law protects you from higher bills when:

- You're getting emergency care from an out-of-network provider or facility, or
- An out-of-network provider is treating you at an in-network hospital or ambulatory surgical center without getting your consent to receive a higher bill.

Ask your health care provider or patient advocate if you're not sure if these protections apply to you.

If you sign this form, be aware that you may pay more because:

- You're giving up your legal protections from higher bills.
- You may owe the full costs billed for the items and services you get.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, you can also ask your health plan if they can work out an agreement with this provider or facility (or another one) to lower your costs.

See the next page for your cost estimate.

Estimate of what you could pay if you give up your protections

Patient name: _____

Out-of-network provider(s) or facility name: _____

Total cost estimate of what you may be asked to pay:	
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- ▶ **Review your detailed estimate.** See Page 4 for a cost estimate for each item or service you'll get.
- ▶ **Call your health plan.** Your plan may have better information about how much you'll be asked to pay. You also can ask about what's covered under your plan and your provider options.
- ▶ **Questions about this notice and estimate?** Contact [Enter contact information for a representative of the provider or facility to explain the documents and estimates to the individual, and answer any questions, as necessary.]
- ▶ **Questions about your rights?** Contact [Insert contact information for appropriate federal or state agency. The federal phone number for information and complaints is: 1-800-985-3059]

Prior authorization or other care management limitations

[Enter either (1) specific information about prior authorization or other care management limitations that are or may be required by the individual's health plan or coverage, and the implications of those limitations for the individual's ability to receive coverage for those items or services, or (2) include the following general statement:

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover the items or services before you can get them. If your plan requires prior authorization, ask them what information they need for you to get coverage.]

[In the case where this notice is being provided for post-stabilization services by a nonparticipating provider within a participating emergency facility, include the language immediately below and enter a list of any participating providers at the facility that are able to furnish the items or services described in this notice]

Understanding your options

You can get the items or services described in this notice from the following providers who are in-network with your health plan:

More information about your rights and protections

Visit [Insert website describing federal protections, such as www.cms.gov/nosurprises/consumers] for more information about your rights under federal law.

More details about your total cost estimate

Patient name: _____

Out-of-network provider(s) or facility name: _____

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. This means that **the final cost of services may be different than this estimate.**

Contact your health plan to find out if your plan will pay any portion of these costs, and how much you may have to pay out-of-pocket.

[Enter the good faith estimated cost for the items and services that would be furnished by the listed provider or facility plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services. Assume no coverage would be provided for any of the items and services.]

For each provider or facility described in the notice, fill-in the table below by completing each column for each item and service to be provided by the provider or facility. Add additional rows if necessary. If the notice is for more than one facility or provider, list items and services to be provided by the same facility or provider in adjacent rows, and provide a subtotal estimate for each facility and provider(s). If the notice is for one facility or one provider, the subtotal estimate may be omitted. The total amount on page 2 must be equal to the total of each of the cost estimates included in the table.]

Date of service	Name of Provider or Facility	Service code	Description	Estimated amount to be billed
Subtotal for [insert name of provider or facility]:				
Total estimate of what you may owe:				