California Skin Surgery Center
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Billing Disclosures – Your Rights and Protections Against Surprise Medical Bills

Beginning January 1, 2022, healthcare facilities must provide a good faith estimate of expected charges to ***uninsured consumers***, or to insured **consumers if the patient does not plan to have their health plan help cover the costs (self-paying individuals).** The good-faith estimate must be provided after a patient has scheduled a surgery, or upon their request. It should include expected charges for the primary item or service they're getting, and any other items or services that are provided as part of the same scheduled experience.

"Surprise billing" is an unexpected balance bill. "Out-of-network" describes a facility that has not signed a contract with your health plan. If you have an ***emergency medical condition and get emergency services,*** the most the facility may bill to you is the in-network cost-sharing amount

As the patient, you have the following protections:

1. You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. Under the law, healthcare providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- Make sure your healthcare provider gives you a Good Faith Estimate in writing at least one business day before your medical service or item. You can also ask your healthcare 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. For questions or more information about your right to a Good Faith Estimate, visit **cms.gov/nosurprises** or call
- **1-800-MEDICARE** (**1-800-633-4227**).

2. You are protected from balance billing for 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 may bill you is your plan's in-network cost-sharing amount. 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.

3. 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.

4. 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:
    - 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 (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 deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact:

Contact our billing department right away so we can help. Be sure to have a copy of thebill available.
Visit cms.gov/nosurprises for more information about your rights under federal law. Visit healthhelp.ca.gov for more information about your rights under California law.