LONE TREE
SURGERY CENTER, LLC

Patient Label

Surprise/Balance Billing Disclosure Form
Surprise Billing - Know Your Rights

Colorado and federal law protect you* from "surprise billing," also known as "balance billing." These protections apply when:

You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or

You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado.

What is 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 is not in your health plan's network. "Out-of-network" means providers and facilities that have not 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 often 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 cannot control who is involved in your care – for example when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly having to be treated by an out-of-network provider. Surprise medical bills could be substantial depending on the procedure or service.

The Colorado law applies if you have a CO-COI" on your health insurance ID card and you are receiving care and services provided at a regulated facility in Colorado. If you are not a Colorado resident or your health insurance card does not contain the CO-COI designation because your plan is not regulated by Colorado, the federal surprise billing law provides you with substantially similar protection.

When you CANNOT be surprise billed:

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 are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
Other Services
Similarly, you are protected from surprise billing and cannot be asked to waive those protections for the following services.

Anesthesiology.
Pathology.
Radiology.
Neonatology.
Services provided by assistant surgeons, hospitalists, and intensivists.
Diagnostic services including radiology and laboratory services, and

Services provided by an out-of-network provider if there is no in-network provider who can provide the service at the facility.

Be Prepared to Avoid Balance Billing. In order to be informed and protect yourself from balance or surprise billing, even when the law provides those protections, we encourage you to:

Call your insurance company's member benefits number or help line before making an appointment for any sort of procedure. Ask about your plan's coverage and network. Also ask if the services you need should be free. Preventative healthcare services should have no copay.
Confirm with your doctors that they are in-network, and that other involved providers will also be in-network. You can also double-check any expected charges with your provider before going to your appointment.
Ask for explanations regarding services and procedures your doctors prescribe. Make sure that you understand why each is necessary, and what the associated costs are.
Remember—it's always ok to ask questions!

Non-emergency Services at an In-Network Facility by an Out-of-Network Provider

Facility or agency staff must tell you if you are at an out-of-network location or if they are using out-of-network providers, when known. Staff must also tell you what types of services you will be using might be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. If your insurance covers the service, you can only be billed for your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance. In this case, the most you can be billed for covered services is your in-network cost-sharing amount, which are co-payments, deductibles, and /or coinsurance.

You're never required to give up your protections from balance billing. You also are not required to get out-of-network care. You can choose a provider or facility in your plan's network.

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Additional Protections

Your insurer will pay out-of-network providers and facilities directly.

Your insurer must count any amount you pay for emergency services or certain out-of-network services toward your in-network deductible and out-of-pocket limit; cover emergency services without requiring you to get approval for those services in advance (prior authorization); cover emergency services by out-of-network providers; and 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.

The provider, facility, hospital, or agency must refund any amount you overpay within sixty days of being notified.

No one, including a provider, hospital, or insurer can ask you to limit or give up these rights.

If you receive services from an out-of-network provider or facility or agency in any other situation, you may still be surprise billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out of network provider or facility, you may also be surprise billed.

If you think you have received a bill for amounts other than your copayments, deductible, and/or coinsurance, we suggest that you use the following procedure:

Contact your insurer about the bill; ask for clarification; make sure that your insurer received a claim for the services for which you are being billed; ask if you are being held responsible for part of the billed amount or the entire bill; and ask for written details about the bill and the part of your health plan that is being applied.

File a complaint with your insurer. If your insurer does not agree to pay the claim, and you think it should be covered, you have the right to appeal within 180 days of your denied claim. An appeal means that you are asking your insurer to reconsider their decision not to pay. Keep in mind that if your bill is a true balance bill, the insurance company may not have been asked to pay, and you can send them a copy to take care of it for you.

Make sure you take notes of all telephone calls and keep copies of all communications and paperwork.

If you have not resolved the issue, please contact the facility's or agency's billing department or the Colorado Division of Insurance at 303-894-7499 or 1-800-930-3745 or, if you are covered by the federal no surprises act, contact The U.S. Centers for Medicare & Medicaid Services (CMS) at **1-800-MEDICARE** (1-800-633-4227) or visit **https://www.cms.gov/nosurprises** for more information about your rights under federal law.
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_____ Date _____

My signature acknowledges receiving this notice and does not waive my rights under the law.