



No Surprises Act & Good Faith Estimates

You are 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 the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You cannot 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 balance 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 may 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 cannot 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 cannot balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections 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 is not 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 are uninsured or self-pay:

Good Faith Estimates

Cost estimates are available to **uninsured and self-pay patients**. A good faith estimate is only an estimate of items or services reasonably expected to be furnished at the time the estimate is issued. Actual items, services, or charges may differ from the good faith estimate; there also may be additional items or services your provider recommends as part of the course of care that must be scheduled or requested separately and are not reflected in the estimate.

Your Rights: You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. Make sure your healthcare provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. If you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill.

If you believe you have been wrongly billed, you may contact **1-877-696-6775** or visit www.cms.gov/nosurprises for more information about your rights under federal law.

To request a Good Faith Estimate from Movement Orthopedics, please contact our billing department at **(586) 436-3785, ext. 107**.