

Effective January 1, 2022 You have the right to receive a “Good Faith Estimate.”



A Good Faith Estimate (GFE) explains your expected medical costs. The GFE is provided in advance of a scheduled appointment.

Under the law, health care providers need to give **patients who do not have insurance or are not using insurance** an estimate of the bill for non-emergency medical items and services. This includes expected costs of items and services like medical tests, prescription drugs, and equipment related to the primary scheduled service.

The Good Faith Estimate does not include potential costs due to complications or special circumstances found during treatment and is not a contract for services. Patients are not required to utilize services identified on a Good Faith Estimate.

Good Faith Estimates are required for patients who:

- Schedule their appointment 3 days in advance
- Are uninsured
- Do not have coverage for a scheduled service
- Elect to pay out-of-pocket and not use their insurance coverage

Patients may also request a Good Faith Estimate before scheduling any service.

Eisner Health offers several financial assistance options. Please contact the billing department at (213) 342-3354 or email billing@eisnerhealth.org.

If you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill.

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 statement. Make sure to save a copy or picture of your Good Faith Estimate.

For answers to questions or to get more information about your right to a Good Faith Estimate, visit [cms.gov/nosurprises](https://www.cms.gov/nosurprises).



Your Rights and Protections Against Surprise Medical Bills



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

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, such as a copayment, coinsurance, and/or a deductible. You may have other costs or may 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” describes providers and facilities that haven't 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 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 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 can't be balance billed for these emergency services. This includes services you may get after you're in a 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 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.

You're never required to give up your protection 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.

- You are only responsible for paying your share of the cost (like the copayments, coinsurance and a deductible 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 wrongfully billed, you may contact the Centers for Medicare & Medicaid Services' No Surprises help desk at **(800) 985-3059**.

Visit dmhc.ca.gov or call **(888) 466-2219** for more information about your rights under California state law.