## Model Disclosure Notice Regarding Patient Protections Against Surprise Billing Instructions – Based on CMS Model Notice

##  (For use beginning January 1, 2022)

Federal law (Section 2799B-3 of the Public Health Service Act (“PHS Act”)) requires health care providers and facilities to make publicly available information regarding their rights against balance billing. These providers make this information publicly available by posting on their website in a prominent location and providing a one-page notice to insured patients who receive health care services from the provider. The notices must be clear and understandable, and include the following information:

1. the 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 in the case that an individua l believes that a provider or facility has violated the restrictions against balance billing.

Health care providers and facilities may use the model notice included as Attachment A to meet these disclosure requirements. Federal regulators consider the use a model notice that meets the requirements as compliance in good faith compliance section 2799B-3 of the PHS Act and 45 CFR 149.430. Indiana has not yet developed model balance billing language or forms. If Indiana develops such language and it 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 model language to be compliant with the federal requirement to include information about state law protections.

## Public Disclosure Requirements

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

* **Publicly Available**. 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 does not have a publicly accessible location.
* **Public website**. If the health care facility or provider maintains a website, the provider may create a link to the notice that appears in a prominent location, such as a searchable homepage on the website.

## One-page disclosure notice

 **Who receives one?**

* 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 individual in a health benefits plan under the Federal Employees Health Benefits Program; and
* to whom they furnish items or services, and then only if such items or services are furnished at a health care facility, or in connection with a visit at a health care facility.

## How is it furnished?

* Providers and facilities must provide the notice in-person, by mail, or via email, as selected by the individual.
* Providers and facilities must issue the disclosure notice no later than the date and time on which 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, the notice must be provided no later than the date on which the provider or facility submits a claim for payment to the plan or issuer.

**What are the form requirements?**

* The disclosure notice must be limited to one-page (double-sided) and must use a font size of 12-points or larger.
* Health care providers, facilities, plans, and issuers should use plain language in the disclosure notice and test the notice for clarity and usability when possible. Plain language, accessibility, and language access resources may be located at the following:

[Plainlanguage.gov/guidelines](https://www.plainlanguage.gov/guidelines/)

[Section508.gov](https://accessibility.gov/)

[LEP.gov](https://www.lep.gov/)

## Compliance with Federal Civil Rights Laws

Entities that receive federal financial assistance (“Covered Entities”) must comply with federal civil rights laws that prohibit discrimination on the basis of classes of individuals enumerated in the law. Such protections include taking 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. Information about these requirements may be accessed through the Office for Civil Rights’ Section 1557 website, available at <https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html>

To comply with the effective communication requirements of Section 1557 and section 504 for individuals with disabilities, Covered Entities should include provision of appropriate auxiliary aids and services, which 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.

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**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 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 cannot select 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 receive after you are in a 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 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 seek your consent 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. An out-of-network provider must give you a notice at least 5 business days before the services are scheduled to be provided, and include a notice summarizing your balance billing rights, including forth a good faith estimate of the charges for such services, and notifying you of the provider’s obligation to explain any charges that exceed the good faith estimate.

**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.**

**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 the Indiana Department of Insurance by calling (317) 232-8582. You may also visit the Indiana Department of Insurance’s website (<https://www.in.gov./idoi>) for more information about Indiana’s balancing billing laws.

You may visit <https://www.cms.gov/nosurprises/consumers> for more information about your rights under federal law.

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