No Surprises Act

We participate with most local and many national insurance plans. However, it is your responsibility to understand whether your insurance has limits on the doctors you can see or the services you can receive.

If you provide complete and accurate information about your insurance, we will submit claims to your insurance carrier and receive payments for services. Depending on your insurance coverage, you may be responsible for co-payments, co-insurance, or other deductible amounts.

Please call your insurance carrier or contact our billing office should you have questions.

Visits scheduled outside our posted hours or during our evening, weekend, or holiday hours are subject to an additional charge billed to your health insurance provider.

Your Rights and Protections Against Surprise Medical Bills

Please contact our billing department at **(513) 248-3063** if you need a Good Faith Estimate before your upcoming appointment.

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 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 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 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 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.

The law, which became effective on January 12, 2022, protects patients from receiving and paying surprise medical bills above the patient's in-network rate from health care providers for emergency care or, in certain circumstances, unanticipated out-of-network care. Cost sharing amounts, which include coinsurance, copayments, and deductibles, are limited to the patient's in-network amounts.

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 https://www.cms.gov/nosurprises/consumers

Visit https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf for more information about your rights under federal law.

Visit https://insurance.ohio.gov/strategic-initiatives/surprise-billing/resources/01-surprise-billing for more information about your rights under Ohio laws.