

## 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 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 balance billed for these post-stabilization services.

*[Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language as appropriate]*

#### **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.**

*[Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language regarding applicable state law requirements as appropriate]*

### **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 *[applicable contact information for entity responsible for enforcing the federal and/or state balance or surprise billing protection laws]*.

Visit *[website]* for more information about your rights under federal law.

*[If applicable, insert: Visit [website] for more information about your rights under [state laws].]*

## FRONT DESK SELF PAY 2022

CPT Codes	Description	Patient Self Pay Amt
31630	Brochoscopy	\$ 240.00
32555	Thoracentesis, needle/cathet w/imaging	\$ 400.00
76604	Ultrasound Office	\$ 72.00
85610	Prothrombin Tm	\$ 7.00
90471	Flu only Immunization Administration	\$ 21.00
90472	Flu/Pneu Immunization Administration	\$ 21.00
90694	Influenza Vaccine	\$ 80.00
90756	Influenza Vaccine	\$ 35.00
90732	Pneumonia Vaccine	\$ 165.00
90670	Pneumonia Vaccine	\$ 290.00
90677	Prevnar 20	\$ 318.00
90791	Psych diagnostic evaluation	\$ 214.00
90792	Psych diagnostic evaluation	\$ 240.00
90832	Psychotherapy 16-37 minutes	\$ 94.00
90834	Psychotherapy 38-52 minutes	\$ 123.00
90837	Psychotherapy >53 minutes	\$ 181.00
92507	Speech Therapy	\$ 94.00
92523	Speech Cognitive Eval	\$ 281.00
92526	Dysphagia Therapy	\$ 104.00
92610	Dysphagia Eval	\$ 105.00
92612	Fiber Endo Swallow Therapy	\$ 238.00
92950	Resuscitation	\$ 406.00
93005	Ecg Routine Ecg W/Least 12 Lds Trcg Only	\$ 7.40
93015	Cv Strs Tst Xers&/Or Rx Cont Ecg Phys Si	\$ 87.00
94010	Spirometry	\$ 33.00
94060	Bronchodialation Responsiveness	\$ 48.00
94070	Bronchospasm Provocation Evaluation	\$ 76.00
94617	Excercise Test for Bronchospasm	\$ 108.00
94618	Pulmonary Stress Test (6 minute walk)	\$ 41.00
94621	Cardiopulmonary exercise testing	\$ 189.00
94640	Pressurized or non pressurized Inh	\$ 14.00
94660	Continuous Positive Airway Pressure	\$ 78.00
94664	Demo of Inhaler	\$ 20.74
94726	PFT- Box w/wo Raw	\$ 67.00
94727	PFT No box Washout Method	\$ 54.00
94728	PFT Oscillometry	\$ 49.00
94729	DLCO/Diffusion Capacity	\$ 72.00
94761	Pulse Ox during exercise	\$ 5.00
94762	Overnite Pulse Ox	\$ 33.00
95004	Perq Tsts W/ Allgic Xtrcs Immt Rxn	\$ 5.00
95012	Niox	\$ 25.00
95800	Home Sleep Study	\$ 196.00
95803	Actigraphy Testing	\$ 75.00

## FRONT DESK SELF PAY 2022

95805	Sleept Test Multiple Latency	\$	510.00
95806	Sleep Test	\$	112.00
95807	Pap Nap	\$	463.00
95810	Sleep Test	\$	743.00
95811	Sleep Test	\$	775.00
96156	Behavior Health Assessment/Reassessment	\$	117.00
96372	Xolair Injection	\$	25.00
96401	Xolair Injection	\$	93.00
97129	Dysphagia Therapy	\$	28.00
97130	TherapInterven Cognitive Funct add15 min	\$	27.00
99152	Initial 15 mins sedation by same physici	\$	16.00
99202	Office New Patient	\$	89.00
99203	Office New Patient	\$	136.00
99204	Office New Patient	\$	203.00
99205	Office New Patient	\$	268.00
99211	Office Established Patient	\$	29.00
99212	Office Established Patient	\$	69.00
99213	Office Established Patient	\$	110.00
99214	Office Established Patient	\$	155.00
99215	Office Established Patient	\$	219.00
99406	Tobacco Use Cessation Intermediate 3-10	\$	19.00
99407	Tobacco Use Cessation Intensive >10 Minu	\$	35.00
99441	Physician Telephone Evaluation 5-10 Min	\$	68.00
99442	Physician Telephone Evaluation 11-20 Min	\$	110.00
99443	Physician Telephone Evaluation 21-30 Min	\$	155.00
99453	Remote Patient Monitor Initial Setup	\$	23.00
99454	Remote Physiologic Monitoring Device	\$	67.00
99457	Remote Patient Monitoring 20 mins or mor	\$	60.00
99458	Remote Patient Monitoring ea add 20 min	\$	49.00
99439	Chronic Care Mgmt Add on Code	\$	58.00
99490	CCM	\$	77.00
G0179	Md Re-Cert Home Health	\$	50.00
G0180	MD Certification Home Health	\$	64.00
G0399	Home Sleep Study	\$	123.00
G0008	Flu Immunization Administration	\$	-
G0009	Pneumononia Immunization Administration	\$	-
J0517	Fasenra Drug	VARIABLE	
J2182	Nucala Drug	VARIABLE	
J2357	Xolair Drug	VARIABLE	
J2920	Methylprednisolone	\$	5.50

## Hospital Self Pay 2019

CPT Code	Description	Patient Self-Pay Amt
31500	Intubation, Endotracheal, ER	\$ 171.00
31502	Trach tube change	\$ 43.00
31600	Trachs Plnd Spx	\$ 370.00
31622	Bronchoscopy, Rigid or Flexible	\$ 159.00
31623	Bronchoscopy, Rigid or Flexible	\$ 160.00
31624	Bronchoscopy, Diagnostic	\$ 162.00
31625	Bronchoscopy, Rigid or Flexible	\$ 189.00
31626	Bronchoscopy w/markers	\$ 237.00
31627	Electromagnetic navigation bronchoscopy	\$ 117.00
31628	Bronchoscopy, Rigid or Flexible	\$ 212.00
31629	Bronchoscopy, Rigid or Flexible	\$ 225.00
31630	Brnchsc W/Tracheal/Brncl Dilat/Clsd Rdct	\$ 239.00
31631	Brnchsc W/Placement Tracheal Stent	\$ 272.00
31632	Bronchoscopy, Rigid or Flexible	\$ 60.00
31633	Bronchoscopy, Rigid or Flexible	\$ 76.00
31635	Brnchsc W/Removal Foreign Body	\$ 211.00
31636	Bronch w/ Stent placement	\$ 262.00
31637	Addtnl Bronch Stented	\$ 93.00
31638	Brnchsc Revj Tracheal/Brncl Stent Ins Pr	\$ 298.00
31640	Brnchsc W/Excision Tumor	\$ 300.00
31641	Bronch w/Stenosis relief	\$ 308.00
31643	Bronch w/Cath Placement	\$ 212.00
31645	Theraputic Bronch	\$ 177.00
31646	Theraputic Bronch Subsequent	\$ 171.00
31647	Bronch w/insert of bronch valve,1st lobe	\$ 249.00
31648	Bronch w/remove of bronch valve 1st lobe	\$ 239.00
31649	Bronch w/remove of bronch valve additional lobe	\$ 81.00
31651	Bronch w/insert of bronch valve,add lobe	\$ 92.00
31652	Bronch w/EBUS and Transbronchial sampling one or two	\$ 267.00
31653	Bronch w/EBUS and Transbronchial sampling tbree or more	\$ 296.00
31654	Bronch with EBUS diagnostic or therapeutic	\$ 81.00
31660	Bronch w/bronch thermoplasty 1st lobe	\$ 237.00
31661	Bronch w/bronch thermoplasty 2 + lobes	\$ 251.00
32550	Insertion Indwelling Tunneled Pleural Cathe	\$ 247.00
32551	Tube Thoracostomy Includes Water Seal	\$ 189.00
32552	Removal Indwelling Tunneled Pleural Cath	\$ 191.00
32554	Thoracentesis, Needle w/o imaging	\$ 108.00
32555	Thoracentesis, Needle w/imaging	\$ 133.00
32556	Pleural Drainage Percataneous w/cath w/o guidance	\$ 150.00
32557	Pleural Drainage Percataneous w/cath w/guidance	\$ 180.00
32561	Initial Day Installation via chest tube	\$ 256.00
32562	Subsequent Day Installation via chest tu	\$ 83.00
36556	Central Line	\$ 102.00
36620	Artl Cahtj/Cannulj Mntr/Transfusion	\$ 54.00

Hospital Self Pay 2019

CPT Code	Description	Patient Self-Pay Amt
75989	Radiology Drg W/Plmt Cath Rs&i	\$ 68.00
76937	Ultrasound Guidance	\$ 17.00
76942	Ultrasonic Guidance (hosp)	\$ 38.00
92950	Cardiopulm Resuscitation	\$ 222.00
92960	Cardioversion Elective Arrhyt Xtrnl	\$ 131.00
93451	Right Heart Cath	\$ 157.00
93463	Drug admin & hemodynmc meas	\$ 119.00
93503	Swan Ganz Catheter	\$ 107.00
94002	Vent Assist	\$ 112.00
94003	Vent Assist	\$ 79.00
99220	Initial Hosp Observation	\$ 214.00
99221	Initial Hosp Care per Day	\$ 120.00
99222	Initial Hosp Care per Day	\$ 162.00
99223	Initial Hosp Care per Day	\$ 237.00
99231	Hospital Follow Up	\$ 47.00
99232	Hospital Follow Up	\$ 86.00
99233	Hospital Follow Up	\$ 123.00
99235	Hosp Observation	\$ 198.00
99238	Hospital Discharge	\$ 86.00
99239	Hospital Discharge	\$ 126.00
99291	Critical Care, Evaluation & Mgmt 0-35 mins	\$ 261.00
99292	Critical Care, Evaluation & Mgmt (36-75 mins)	\$ 132.00
94010h	Spirometry (hosp)	\$ 10.00
94060h	Bronchodialation Responsiveness (hosp)	\$ 13.00
94070h	Bronchospasm Provocation Evaluation(hosp)	\$ 34.00
94726h	PFT -Box w/wo Raw (hosp)	\$ 15.00
94727h	PFT No box Washout Method (hosp)	\$ 15.00
94728h	PFT Oscillometry (hosp)	\$ 15.00
94729h	DLCO/Diffusion Capacity (hosp)	\$ 11.00