Manhattan MRI

Your Rights and Protections Against Surprise Medical Bills

The medical practice of **Manhattan Diagnostic Physicians PLLC d/b/a Manhattan MRI** is out-of-network, which means that neither the practice nor its physicians have signed a contract with your health plan to provide services. However, we do work with plans' out-of-network benefits. As out-of-network providers, we are allowed to bill you for the difference between what your plan pays 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 plan's deductible or annual out-of-pocket limit.

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, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

"Out-of-network" means providers and facilities that have not signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays 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 plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

Good Faith Estimate

If you do not have health insurance or have health insurance but do not plan to file a claim with your health plan, you have the right to receive a "good faith estimate" explaining the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees. You have the right to ask for a good faith estimate before you schedule an item or service. If you receive a bill that is at least $400 more than your good faith estimate, you can dispute the bill.

For questions or more information about your rights regarding a Good Faith Estimate, visit the CMS No Surprises Act website at www.cms.gov/nosurprises.

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 they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** 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 balanced billed for these post-stabilization services.

You are also protected from balance billing under New York law, including for emergency services in hospitals and inpatient care following emergency room treatment. For more information about your rights under New York's law visit the Department of Financial Services website at https://www.dfs.ny.gov/consumers/health_insurance/surprise_medical_bills.

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 can 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 types of 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 out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you also have these protections:

You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility were in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

Generally, your health plan must:

- Cover emergency services without requiring you to get approval for services in advance (also known as "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 in-network deductible and out-of-pocket limit.

If you think you have been wrongly billed and your coverage is subject to New York law ("fully insured coverage"), contact the New York State Department of Financial Services at **(800) 342-3736** or visit https://www.dfs.ny.gov/consumers/health_insurance/surprise_medical_bills for information about your rights under state law. You can also contact the HHS No Surprises Helpdesk at **1-800-985-3059**, which is the entity responsible for enforcing the federal balance or surprise billing protection laws. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.