CMS-10780 Model Disclosure
OMB Control Number: 0938-1401
(Adapted for Indiana Providers)
(HHS Updates 11/30/2021)

ATTACHMENT A
MODEL DISCLOSURE NOTICE REGARDING PATIENT PROTECTIONS AGAINST SURPRISE BILLING

Instructions for Providers and Facilities
(For use beginning January 1, 2022)

Section 2799B-3 of the Public Health Service Act (PHS Act) requires health care providers and facilities to make publicly available, post on a public website of the provider or facility (if applicable), and provide a one-page notice that includes the following information in clear and understandable language:

(1) the federal 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 if an individual believes a provider or facility has violated the restrictions against balance billing.

Health care providers and facilities can, but aren't required to, use this model notice to meet these disclosure requirements. To use this document properly, the provider or facility should review, complete, and provide it in a manner consistent with applicable state and federal law. HHS considers use of this model notice in accordance with these instructions to be good faith compliance with the disclosure requirements of section 2799B-3 of the PHS Act and 45 CFR 149.430, if all other applicable PHS Act requirements are met. If a state develops model or required language for its disclosure notice that 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 language compliant with the federal requirement to include information about state law protections. This form has been adapted to include the model language developed by the Indiana General Assembly concerning surprise billing notice requirements of Indiana law.

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

- **To meet the public disclosure requirement**, 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 doesn't have a publicly accessible location.

- **To meet the separate requirement to post the disclosure on a public website**, the disclosure or a link to the disclosure must be on a searchable homepage of the provider's or facility's public website.

Who should get this notice
In general, providers and facilities must give the disclosure notice to 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 individuals in a health benefits plan under the Federal Employees Health Benefits Program, and
- To whom the provider or facility furnishes items or services, but only if such items or services are furnished at a health care facility, or in connection with a visit at a health care facility.

Providers and facilities shouldn't give these documents to an individual who has Medicare, Medicaid, or any form of cover than previously described, or to an individual who is uninsured.

Providing this notice
Providers and facilities must provide the notice in-person, by mail, or by email, as selected by the individual. The disclosure notice must be limited to one, double-sided page and must use a 12-point font size or larger.

Providers and facilities must issue the disclosure notice no later than the date and time 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, they must provide the notice no later than the date they submit a claim for payment to the plan or issuer.

Language access

Compliance with Federal Civil Rights Laws
Entities that get federal financial assistance must comply with federal civil rights laws that prohibit discrimination. These laws include section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, and section 504 of the Rehabilitation Act of 1973. Section 1557 and title VI require covered entities to take 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.

Sections 1557 and 504 require covered entities to take appropriate steps to ensure effective communication with individuals with disabilities, including provision of appropriate auxiliary aids and services. Auxiliary aids and services 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.

Use of plain language
Health care providers and facilities are encouraged to use plain language in the disclosure notice and test the notice for clarity and usability when possible.

Plain language, accessibility, and language access resources:
- Plainlanguage.gov/guidelines
- Section508.gov
- LEP.gov

NOTE: The information provided in these instructions is intended to be only a general summary of technical legal standards. It isn't intended to take the place of the statutes, regulations, or formal policy guidance on which it is based. Refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

DON'T INCLUDE THESE INSTRUCTIONS WITH THE DISCLOSURE NOTICE GIVEN TO PATIENTS.

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Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charges more than your plan's copayments, coinsurance and/or deductible.

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, and/or a 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 isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't 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 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're 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'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 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 **can't** balance bill you and may **not** ask you to give up your protectionsnot to be balance billed.

- If you get other types of services at an in-network hospital or ambulatory surgical center, out-of-network providers **can't** balance bill you, unless You give written consent and give up your protections.

Estimate of Charges:

An out-of-network provider can't balance bill you unless, at least 5 business days before the services are scheduled to be performed, they give you a good faith estimate of the expected charges for the scheduled services. Indiana law also requires a health care provider or facility to provide an estimate for non-emergency services within 5 business days of receiving a request for one.

You're never required to give up your protections 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.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was 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 inadvance (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 servicestoward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the Indiana Department of Insurance at https://www.in.gov./idoi/consumer-services/ or 1-317-232-8582.

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.