Surprise Billing Protection Form

This document describes your protections against unexpected medical bills. It also asks if you'd like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider before scheduling care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your registration representative. A copy of this form will be provided upon request.

You're getting this notice because this provider or facility isn't in your health plan's network and is considered out-of-network. This means the provider or facility doesn't have an agreement with your plan to provide services. **Getting care from this provider or facility will likely cost you more.**

If your plan covers the item or service you're receiving, federal law protects you from higher bills when:

- You're getting emergency care from an out-of-network provider or facility, or
- An out-of-network provider is treating you at an in-network hospital or ambulatory surgical center without getting your consent to receive a higher bill.

Ask your health care provider or patient advocate if you're not sure if theses protections apply to you.

If you sign this form, be aware that you may pay more because:

- You're giving up your legal protections from higher bills.
- You may owe the full costs billed for the items and services you get.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, you can also ask your health plan if they can work out an agreement with this provider or facility (or another one) to lower your costs.

See next page for your estimate.

Estimate of what you could pay if you give up your protections

Patient name: ____

Out-of-network provider(s)or facility name: ____

Total cost estimate of what you may be asked to pay: ______________________________________

- **Review your detailed estimate**. See Page 4 for a cost estimate for each item or service you'll get.

- **Call your health plan**. Your plan may have better information about how much you'll be asked to pay. You also can ask about what's covered under your plan and your provider options.

- **Questions about this notice and estimate?** Contact the SIH Patient Estimate Department or SIH Medical Groups Teams at 1-888-457-0065.

- Questions about your rights? Contact the Illinois Department of Insurance at 1-877-527-9431 or visit www.cms.gov/nosurprises/consumers or call 1-800-985-3059.

- **Prior authorization or other care management limitations**

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover the items or services before you can get them. If your plan requires prior authorization, ask them what information they need for you to get coverage.

Understanding your options

You can get the items or services described in this notice from the following providers who are in-network with your health plan:

More information about your rights and protections

Visit https://www.cms.gov/nosurprises/consumers or call 1-800-985-3059 for more information about your rights under federal law.

By signing, I understand that I'm giving up my federal consumer protections and may have to pay more for out-of-network care.

With my signature, I'm agreeing to receive the items or services from (select all that apply):

Separately list and check the box for each facility, doctor or provider's name

☐ ____

☐ ____

With my signature, I acknowledge that I'm consenting of my own free will and I'm not being coerced or pressured. I also acknowledge that:

- I'm giving up some consumer billing protections under federal law.
- I may have to pay the full charges for these items and services, or have to pay additional out-of-network cost-sharing under my health plan.
- I was given a written notice on ____/____/____ *[enter date of notice]* that explained my provider or facility isn't in my health plan's network, described the estimated cost of each service, and disclosed what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all of the amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You don't have to sign this form. If you don't sign, this provider or facility might not treat you, but you can choose to get care from a provider or facility that's in your health plan's network.

________________________________	or	________________________________
Patient's signature		Guardian/authorized representative's signature
________________________________		________________________________
Print name of patient		Print name of guardian/authorized representative
________________________________		________________________________
Date and time of signature		Date and time of signature

Take a picture and/or keep a copy of this form.
It contains important information about your rights and protections.

More details about your total cost estimate

Patient name: ____

Out-of-network provider(s) or facility name:
____

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. This means that **the final cost of services may be different than this estimate.**

Contact your health plan to find out if your plan will pay any portion of these costs, and how much you may have to pay out-of-pocket.

Date of Service	Name of Provider or Facility	Service Code	Description	Estimated amount to be billed
Subtotal for [name of provider of facility]:				
Total estimate of what you may owe:				

Limited English Proficiency Notification

As required to meet compliance with the No Surprises Act

ATTENTION: If you do not speak English and need this form translated, please ask a staff member to arrange for language interpretation. It is free of charge.

ATENCIÓN: Si no habla inglés y necesita traducir este formulario, pídale a un miembro del personal que coordine la interpretación del idioma. Es gratis.

UWAGA: Jeśli nie mówisz po angielsku i potrzebujesz przetłumaczyć ten formularz, poproś członka personelu o zorganizowanie tłumaczenia ustnego. To jest bezpłatne.

注意：如果您不会说英语并需要翻译此表格，请让工作人员安排语言翻译。这个是免费的。

주의: 영어를할수없고이양식을번역해야하는경우직원에게언어통역을요청하십시오. 무료입니다.

Pansin: Kung hindi ka nagsasalita ng Ingles at kailangan ang form na ito na isinalin, mangyaring hilingin sa isang kawani na mag-ayos para sa interpretasyon ng wika. Ito ay walang bayad.

تنبيه: إذا كنت لا تتحدث الإنجليزية وتحتاج إلى ترجمة هذا النموذج ، فيرجى مطالبة أحد الموظفين بترتيب الترجمة الفورية للغة. إنه مجاني

ВНИМАНИЕ: Если вы не говорите по-английски и вам нужен перевод этой формы, попросите сотрудника организовать языковой перевод. Это бесплатно.

યાન આપો: જો તમે અં ે નથી બોલતા અને આ ફોમના અનુવાદની જ ર હોય, તો કૃપા કરીને ટાફ સ યને ભાષાના અથઘટનની યવ થા કરવા માટે કહો. તે િન:શુ ક છે.

توجہ: اگر آپ انگریزی نہیں بولتے اور اس فارم کا ترجمہ درکار ہے، تو براہ کرم عملے کے کسی رکن سے زبان کی تشریح کا بندوبست کرنے کو کہیں۔ یہ مفت ہے۔

LƯU Ý: Nếu bạn không nói được tiếng Anh và cần dịch mẫu đơn này, vui lòng yêu cầu nhân viên sắp xếp thông dịch ngôn ngữ. Nó là miễn phí.

ATTENZIONE: Se non parli inglese e hai bisogno di tradurre questo modulo, chiedi a un membro dello staff di organizzare l'interpretazione linguistica. È gratuito.

ान द: यिद आप अं ेजी नहींबोलते ह और इस फॉम का अनुवाद करना चाहते ह, तो कृ पया िकसी ाफ सद से भाषा की ा ा की व था करने के िलए कह। यह िबना मू के है।

ATTENTION : Si vous ne parlez pas anglais et que vous avez besoin de traduire ce formulaire, veuillez demander à un membre du personnel d'organiser l'interprétation linguistique. C'est gratuit.

ΠΡΟΣΟΧΗ: Εάν δεν μιλάτε αγγλικά και χρειάζεστε μετάφραση αυτού του εντύπου, ζητήστε από ένα μέλος του προσωπικού να κανονίσει τη διερμηνεία γλώσσας. Είναι δωρεάν.

ACHTUNG: Wenn Sie kein Englisch sprechen und dieses Formular übersetzt werden müssen, bitten Sie einen Mitarbeiter, für eine Sprachübersetzung zu sorgen. Es ist kostenlos.