YOU HAVE THE RIGHT TO A

GOOD FAITH ESTIMATE

Under the law, health care providers are to give patients who do not have insurance or who are not using insurance, a good faith estimate of the bill for a scheduled service.

If you do not have insurance or are not using insurance for a scheduled service, your healthcare provider will provide a good faith estimate of the expected charges known at the time of scheduling prior to the date of your scheduled service. You can also ask your health care provider, and any other provider you choose, 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. Make sure to save a copy or picture of your good faith estimate.

For questions or more information about your right to a Good Faith Estimate or ability to dispute your bill, visit www.cms.gov/nosurprises or call 1-800-985-3059.

Below you will find your estimated patient responsibility for your scheduled hospital services.

ESTIMATED PATIENT FINANCIAL OBLIGATION SUMMARY

Patient Name: RONNIE WEBBER **Date of Service:** 11/05/2021 **Account Number:** RONNIEWEBBER1961-06-2611052021

Patient Type: Outpatient

Benefit Details (received from your insurance company 11/05/2021

Individual Deductible	$750.00	Individual Deductible Met	$750.00
Individual OOP	$2,400.00	Individual OOP Met	$1,237.24
Family Deductible	$2,250.00	Family Deductible Met	$750.00
Family OOP	$7,200.00	Family OOP Met	$1,237.24

Deductible:	$0.00
Co-Payment:	$0.00
Co-Insurance:	$94.91
Non-Covered:	$0.00
Estimated Patient Payment*:	**$94.91**

Procedures	Copay ($)	Co-Insurance %	Charges($)	Plan Allowed($)
CT ANGIO CHEST W/DYE		10.00	$3,134.40	$949.10
		Totals	$3,134.00	$949.10

This good faith estimate is not a contract and does not require you to obtain the items or services from any of the providers or facilities identified in the good faith estimate.

This good faith estimate is not a guarantee of the amount you will be billed or required to pay for the services requested. It is based on an average amount billed to patients historically that have had this service at this facility and shows the costs of items and services that are reasonably expected for your health care needs. This estimate is also based on the information known at the time the estimate was created. It does not include any unknown or unexpected costs that may arise during treatment.

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Final billed charges may vary for many reasons, including the patient's medical condition, unknown or unanticipated circumstances or complications, individual medical needs, final diagnosis, changes to the initial treatment plan or unexpected complications.

There may also be additional items or services recommended or requested that is not a part of this estimate. The following list includes additional services that you may receive before or after the items and services listed on this estimate but will be separately scheduled and if applicable separate good faith estimates will be issued for additional hospital services that are scheduled or upon request. The below list does not include information such as diagnosis codes, service codes, expected charges and provider or facility identifiers, as such information will be provided with the good faith estimate(s) that are separately issued for any hospital services scheduled. To obtain good faith estimate(s) for additional scheduled hospital services, please contact 828-894-0959.

Services may include the following and will be dependent upon your provider's recommendations and the type of service you are receiving:

- Pre or post operative visits
- Anesthesia consultation
- Laboratory tests
- Radiology procedures

If you are billed an amount substantially more than this good faith estimate, you have the right to dispute the bill. You may start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this good faith estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount. The initiation of the dispute resolution process will not adversely affect the quality of health care services furnished by a provider or facility.

To learn more and get a form to start the process, go to: https://www.cms.gov/nosurprises/consumer-protections/Payment-disagreements or call 1-800-985-3059
You may also receive bills from independent contractors that are not employees or agents of St. Luke's Hospital for certain services, including but not limited to radiology, pathology, anesthesiology or other lab charges. Until further notice, you may directly request good faith estimates from those providers.
Please keep a copy of this good faith estimate for your records

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