Dermpath Diagnostics®

Your rights and protections against surprise medical bills

If you are not using insurance, you have the right to receive a good faith estimate explaining how much your medical care will cost. Under the law, healthcare providers need to give self-pay patients—patients who don't have insurance or who are not using insurance—an estimate of their bill for medical items and services.

- If you are not using insurance, you have the right to receive a good faith estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees
- Make sure your healthcare provider gives you a good faith estimate in writing at least 1 business day before your medical service or purchase of a non-emergency item. You can also ask your healthcare provider, and any other provider you choose, for a good faith estimate before you schedule service or purchase 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 call **1.866.625.3309**.

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 surprise billing or balance billing.

What is balance billing (sometimes referred to as surprise billing)?

When you see a healthcare provider, you may owe certain out-of-pocket costs, such as a copayment and/or a deductible. You may have other costs or the entire bill if you see a provider or visit a healthcare facility that isn't in your health plan's network. The difference between what your plan agreed to pay and the full amount charged for a service is called balance billing. Surprise billing is an unexpected balance bill.

Emergency services

You are protected from balance billing for emergency services from an out-of-network provider or facility. The most the provider/facility may bill you is your plan's in-network cost-sharing amount. In connection with emergency services, you can't be balance billed. This includes services you may get after you're in stable condition unless you give written consent and give up your protections.

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. These out-of-network providers can't balance bill you unless you give written consent and give up your protections.

When balance billing isn't allowed, you also have the following protections

You are only responsible for paying your share of the cost 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
- Base what you owe on what it would pay an in-network provider or facility
- 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 believe you've been wrongly billed, you may contact your provider. If unresolved, you may contact the US Department of Health and Human Services (HSS) or your State Insurance Department. For more information about your rights, visit **hhs.gov**.

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Test name	CPT code(s)	Price	Common ICD-10 codes	Possible additional tests	Possible additional CPT codes
Tissue Level III	88304	$100.00	L91.8, L72.0, T85.79XA	Special Stains; IHC Antibodies/ Immunofluorescence	88312, 88342, 88346
Tissue Level IV	88305	$135.00	D22.5, L82.0, D23.5	Special Stains; IHC Antibodies/ Immunofluorescence	88312, 88342, 88346
Tissue Level V	88307	$292.00	N87.0, M86.172, M46.28	Special Stains; IHC Antibodies/ Immunofluorescence	88312, 88342, 88346
Tissue Special Stains —Group 1	88312	$125.00	L30.8, B35.1, L30.9		
Tissue Special Stains —Group 2	88313	$125.00	L81.8, L30.8, L01.02		
Tissue IHC Antibody —Additional Stains	88341	$155.00	D48.5, C85.11, D04.39		
Tissue IHC Antibody —1st stain	88342	$155.00	T85.79XA, D48.5, D23.5		
Immunofluorescence —1st stain	88346	$140.00	R21, L10.9, L30.8		
Immunofluorescence —Additional Stains	88350	$140.00	R21, L10.9, L30.8		
Flow Cytometry	88185	$100.00	D50.9, C85.11		

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