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YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS
(OMB Control Number: 0938-1401)

When you get emergency care or get 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 called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a healthcare facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of network providers may be permitted to bill you for the difference between what your plan agreed to pay 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 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.

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 the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). 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 may be out-of-network. In these cases, the most that those providers may 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 protections not to be "balance billed".

If you get other services at these in-network facilities, out-of-network providers can't "balance bill" you unless you give written consent and give up your protections.

You're never required to give up your protection from "balance billing". You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles 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 (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 deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may visit www.cms.gov/nosurprises.

GOOD FAITH ESTIMATE OF EXPECTED FEES

Under the law, (Section 2799B-6 of the Public Health Services Act), health care provider must provide patients who don't have insurance or who are not using their insurance, with an estimate of expected charges for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any nonemergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- This document is your "Good Faith Estimate." The Good Faith Estimate shows the costs that are reasonably expected for services provided by your Therapist. The estimate is based on the information known at the time the estimate was created. It does not take into account any reimbursement you may receive as part of your out-of-network benefits.
- The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment.
    - Your cost could increase if you experience complications or special circumstances such that additional psychotherapy sessions are needed, or if you choose to schedule additional sessions at your discretion.
    - Your cost could be much less than the amount of the Good Faith Estimate, depending on how long you decide to remain in therapy and the amount of reimbursement you receive as part of your out-of-network benefits.

If you are billed unexpectedly for more than the amount listed on your Good Faith Estimate, you have the right to dispute the charges. You may contact the health care provider or facility listed

to let them know the billed charges are higher than outlined in the Good Faith Estimate. You can ask them to update the bill to match the rates you were quoted in the Good Faith Estimate, ask to negotiate any unexpected charges that were billed at a higher rate then you were quoted, or ask if there is financial assistance available to pay for unexpected charges.

You may also 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 (about 4 months) of the date of service.

The agency reviewing your dispute charges 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.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.