

Good Faith Estimate

You have the right to receive a “Good Faith Estimate” explaining how much your medical care will cost.

Under the law, health care providers need to give **patients who don’t have insurance or who are not using insurance** an estimate of the bill for medical items and services.

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 health care provider gives you a Good Faith Estimate in writing at least one (1) business day before your medical service or item. 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, visit www.cms.gov/nosurprises or call 1-800-985-3059.

If you believe you've been wrongly billed, you may contact Fundamental Psychology by calling **941-275-9183**.

No Surprises Act

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider you are protected from surprise billing or balance billing.

Note: No Surprises Act doesn't apply to individuals with coverage through programs such as Medicare, Medicare Advantage, Medicaid, Medigap and the Children's Health Insurance Program (CHIP).

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 health care 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 - such as 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.

Why am I receiving this notice?

You are receiving this notice because:

- o You are a covered individual under a group health plan or a health plan offered by a health insurance issuer, like the Federal Employees Health Benefits Program; and
- o Your doctor or this health care facility is going to provide a treatment or service for which the provider or health care facility is going to ask you to pay a copayment, coinsurance, or deductible or is going to submit a bill to your health plan.

For what types of services am I protected from balance billing?

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 receive services from an in-network hospital or ambulatory surgical center, certain providers at that facility may be out-of-network. In

these cases, the most 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.

You're never required to give up your protections 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.

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.

When balance billing isn't allowed, what other protections do I have?

You are only responsible for paying your share of the cost (such as copayments, coinsurance and/or 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:

- o Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- o Cover emergency services by out-of-network providers.
- o 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.
- o Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.