Notification of Federal Protections Against Surprise Billing

Un-insured Clients

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 an estimate of the bill for medical items and services to **clients who don't have insurance or who are not using insurance**. These clients:

- Have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services offered Prairie Winds Counseling, Inc.
- Shall be provided with a Good Faith Estimate in writing prior to your mental health service and can ask for a Good Faith Estimate during scheduling.
- If you receive a bill that is at substantially higher than estimated on (more than $400 than) your Good Faith Estimate, you can dispute the bill.
- It is a good idea to save a copy of your Good Faith Estimate.

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

Out-of-Network Clients

Getting care from this provider or facility could cost you more (if we are out-of-network):
If you have insurance that we do not work with and choose to proceed working with this clinic or its providers (you are choosing to not use your insurance in-network benefits), getting care from this provider or facility could cost you more than if you went to an in-network provider.

If your insurance plan covers the item or service you are getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your health care provider or client coordinator if you need help knowing if these protections apply to you. According to federal regulations, a waiver can be signed to pay the full fees, which may be more than your in-network benefits, which may mean you have:

- given up your protections under the law.
- you may owe the full costs billed for items and services received.
- Your health plan *might* not count any of the amount you pay toward your deductible and out-of-pocket limit. Contact your health plan for more information (regarding your out of network benefits).

You should not sign any waivers, if you did not have a choice of providers when receiving care. For example, a doctor was assigned to you with no opportunity to make a change (or without choice). Before deciding whether to sign a waiver, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with a provider or facility.

Your Rights and Protections Against Surprise Medical Bills
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 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.

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"**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 (*in network rate*) and the full amount charged (*private fee*) 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, deductible, 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 balance filed 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 there may be out-of-network. In these cases, the most these 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 are never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed (in above mentioned cases), 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.

For more information about your rights under federal law, visit: **https://www.cms.gov/nosurprises/consumer-protections/Payment-disagreements**