NO SURPRISE ACT NOTIFICATION

In compliance with the No Surprises Act (NSA) that went into effect January 1, 2022, we are required to notify all healthcare consumers of your federal rights and protections against "surprise billing."

This Act requires that we notify you of your federally protected rights to receive a notification when services are rendered by a non-participating provider and provide options to receive care from an in-network provider if one is available.

Please read and sign the notice below.

Additionally, we are required to provide you with a **Good Faith Estimate** of the cost of services for the duration of treatment. It is difficult to determine the true length of treatment for mental health care. The Good Faith Estimate (separate document) is our best estimate based on the average length of treatment.

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. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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—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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

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 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. 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 <u>never</u> 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.

<u>Your right to request a good faith estimate for nonemergency health care services under Indiana and Federal law</u>

In Indiana, a patient may ask for an estimate of the amount the patient will be charged for a nonemergency medical service provided. Federal law requires that we provide a good faith estimate within 3 business days of your request, or within 1 or 3 business days of scheduling depending on the date services are to be provided.

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 contact the Indiana Professional Licensing Agency and/or the Department of Insurance to file a complaint:

- For complaints against your provider: https://www.in.gov/pla/file-a-complaint/
- For complaints against your health plan: https://www.in.gov/idoi/consumer-services/complaints/

Visit https://www.cms.gov/nosurprises or dial 1-800-985-3059 for more information about your rights under federal law.

By signing this form, I attest that I received notification of the information presented in this document.

_____
Printed Name of Patient / Guardian / Legal Representative

_____ _____
Signature of Patient / Guardian / Legal Representative Date