This information is relevant for clients who do not have insurance or will be self-paying for their therapy. However, all clients should read and sign it even if you are using insurance for your therapy.

Rights and Protections against Surprise Medical Bills

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 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 healthcare provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional 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" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays 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 plan's deductible or 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're protected by 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 they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). 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. Additionally, Delaware protects patients from balance billing for: (i)

any covered medically necessary services performed by an out-of-network provider when the medically necessary service is not available through in-network providers in a reasonable amount of time, provided the patient has a referral; and (ii) emergency services from an out-of-network provider.

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 can 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 types of 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 out-of-network care. You can choose a provider or facility in your plan's network.

Additionally, Delaware also protects patients for: (i) covered non-emergency services provided at an in-patient or ambulatory facility by an out-of-network provider and/or at an out-of-network facility; and (ii) covered non-emergency services provided by an out-of-network provider unless the patient received and consented to a written disclosure. This protection allows patients to be billed for in-network cost-sharing amounts. These protections apply to patients with coverage through any policy or contract for health insurance delivered or issued in Delaware.

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

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "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 in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact:

The U.S. Centers for Medicare & Medicaid Services (CMS) at **1-800-MEDICARE (1-800-633-4227)** or visit **https://www.cms.gov/nosurprises** for more information about your rights under federal law.

Delaware Department of Insurance Bureau at **302-674-7300.**

Get More Information

For questions or more information about your right to a Good Faith Estimate, visit: **cms.gov/nosurprises (https://www.cms.gov/nosurprises)** or call **1-800-MEDICARE** (1-800-633-4227).

Acknowledgement of Understanding and Acceptance

I am acknowledging that I have read and understand the contents of this notice by my signature below:

____ ______________

Client **Date**

____ ______________

Allied Behavioral Health Therapist **Date**