PEDIATRIC
TREATMENT
GROUP

No Surprises ACT (NSA) Notice
January 2022

Summary of Information
The No Surprises Act, which commenced action in January 2022, is legislature documenting your right as a patient to be informed of estimated costs for services within a Good Faith Estimate from your provider. Dr. Erin Underbrink, within the Pediatric Treatment Group, currently only provides services within a self-pay scenario where you as the patient will be responsible for paying upfront, out of pocket, for your cost of service. Billing for each service will take place automatically following the service, unless previously agreed upon. Dr. Underbrink does not bill insurance and therefore this constitutes a self-pay scenario under the NSA. However, if you are a patient that also has health insurance, you may submit the receipt of service (Super Bill) provided by Dr. Underbrink to your insurance for out-of-network reimbursement.

By federal law, it's required for your providers to notify you of your rights within 2 scenarios:

1) If you are obtaining services at an in-network facility (according to your insurance) but the provider you're seeing is out-of-network. This might apply if you are in a hospital that is in-network, but a specialist you are needing to see is out-of-network. This likely DOES NOT apply to our practice because Dr. Underbrink and PTG is always out-of-network since we do not bill insurance.
2) If you are receiving services at an out-of-network practice. Please note, this may or may not apply to an individual who is receiving services out-of-network and therefore paying out of pocket (self-pay) but then intends on submitting bills to insurance for reimbursement. Because the law is unclear whether this applies, we are going to provide the notice regardless, because you are (likely) enrolled in a group health plan. Scenario 2 applies if you are seeking services with Dr. Underbrink (out-of-network) but are insured and intend to submit for reimbursement.

Although Scenario 2 is likely the only relevant scenario, in order to maintain compliance, both scenario notifications are listed below. You will also receive verbal notification of your good faith estimate of billing (confirmation of our billing agreement) and a notification via the portal.

BELOW is the NOTICE for both Scenario 1 and Scenario 2. You will receive your Good Faith Estimate on another document via the portal and verbally. Your Good Faith Estimate will always be the previously agreed upon session fee multiplied by the number of sessions. For example, if your fee is $200/session, and we are estimating 12 sessions, your Good Faith Estimate of services would be a total cost of 200 x 12= $2400.

Please note: the number of total sessions is unknown and depends on patient need, preference and progress made. If the total number of sessions can be reasonably predicted (i.e., we have agreed upon a set protocol or a program which typically takes a certain number of sessions) then you will be provided a GFE on that predicted number. You will receive a single GFE for these recurring services based on typical, weekly sessions and the standard 3-5 months for treatment,

unless a different program has been selected indicating a different frequency. For example, if you are initiating services for the structured workshop that contains 4-5 sessions, your GFE will indicate this (i.e., $200/session for 5 sessions = GFE of $1000). As a reminder, the GFE is only an ESTIMATE and therefore the charges may be different than the estimate.

You will be asked to provide a signature stating you have received this GFE and notice in order to document your agreement with the GFE. This will be provided in addition to PTG's treatment fee agreement where you also sign consent and agreement for services within Dr. Underbrink's fees. If you are in treatment with Dr. Underbrink for over 12 months you will be provided with another GFE.

If at any time the GFE changes (i.e., treatment switches to multiple times per week or a different service is initiated (Intensive Outpatient Program), you will receive an updated GFE based on the new estimated fees.

If additional chargeable services are indicated during the course of treatment, these will be charged based on the signed agreement at the initiation of treatment. If these are expected they will be added to the Good Faith Estimate at the start. These chargeable services are listed within the fee agreement but may include: report writing, consultation with other providers (i.e. doctors or school staff), parent phone calls, and travel time to off site visits; other items may also be included, this is not an exhaustive list.

Receiving this Good Faith Estimate is not a contract and does not mean you as the patient are required to obtain or pay for these services simply based on the GFE.

You as the self-pay individual have the right to initiate a dispute resolution process of the actual billed charges are substantially in excess of the expected charges including in the good faith estimate. You can initiate the dispute resolution process by visiting www.cms.gov/nosurprises/consumers or call 1-800-985-3059. You can submit an initiation notice to HHS through the online federal IDR portal at home.idm.cms.gov you dispute a bill, this will not adversely affect the quality of psychological services you can obtain by this provider or facility.

As a summary, the current document and following pages are the NOTICE stating that you will be receiving a Good Faith Estimate of the fees you may be charged. You will receive this estimate separately. As a reminder, Scenario #2 is the relevant information for this provider and circumstance.

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Scenario #1: In-network 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 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.

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.

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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.
→Relevant to PTG: Although Dr. Underbrink is out-of-network, you are never required to see Dr. Underbrink and can continue to search for and see a provider within your network. Agreeing to be seen by Dr. Erin Underbrink means agreeing to receiving care out-of-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 contact www.cms.gov/nosurprises/consumers.
Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

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Scenario #2: Right to Receive a Good Faith Estimate of Expected Charges

→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 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

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