

## Federal Notice for Individuals Insured by Group Health Plans & Group/Individual Health Insurance:

### 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:

##### 1. 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 balance billed for these post-stabilization services.

See the attached form for more information about your rights under Virginia law.

##### 2. 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 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.**

See the attached form for more information about your rights under Virginia law.

**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 billing office for Virginia Urology or the Urosurgical Center of Richmond, at 804 330-9105. Or you may contact the U.S. Department of Health and Human Services or the Virginia State Corporation Commission.

- Visit [www.cms.gov/nosurprises/consumers](http://www.cms.gov/nosurprises/consumers) or call 1-800-985-3059 for more information about your rights under federal law.
- Visit [scc.virginia.gov](http://scc.virginia.gov) or call 1-877-310-6560 for more information about your rights under Virginia law.

**Uninsured & Self-Pay Patients:  
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](http://www.cms.gov/nosurprises) or call 804 330-9105.

## BALANCE BILLING PROTECTION FOR OUT-OF-NETWORK SERVICES

**Starting January 1, 2021, Virginia state law may protect you from “balance billing” when you get:**

- **EMERGENCY SERVICES** from an out-of-network hospital, or an out-of-network doctor or other medical provider at a hospital; or
- **NON-EMERGENCY SURGICAL OR ANCILLARY SERVICES** from an out-of-network lab or health care professional at an in-network hospital, ambulatory surgical center or other health care facility.

**What is balance billing?**

- An **“IN-NETWORK”** health care provider has signed a contract with your health insurance plan. Providers who haven’t signed a contract with your health plan are called **“OUT-OF-NETWORK”** providers.
- In-network providers have agreed to accept the amounts paid by your health plan after you, the patient, has paid for all required cost sharing (copayments, coinsurance and deductibles for covered services).
- But, if you get all or part of your care from out-of-network providers, you could be billed for the difference between what your plan pays to the provider and the amount the provider bills you. This is called “balance billing.”
- The new Virginia law prevents certain balance billing, **but it does not apply to all health plans.**

<b>Applies</b>	<b>May Apply</b>	<b>Does Not Apply</b>
<ul style="list-style-type: none"><li>○ Fully insured managed care plans, including those bought through HealthCare.gov</li><li>○ The state employee health plan</li><li>○ Group health plans that opt-in</li></ul>	<ul style="list-style-type: none"><li>○ Employer-based coverage</li><li>○ Health plans issued to an employer outside Virginia</li><li>○ Short-term limited duration plans</li></ul>	<ul style="list-style-type: none"><li>○ Health plans issued to an association outside Virginia</li><li>○ Health plans that do not use a network of providers</li><li>○ Limited benefit plans</li></ul>

**How can I find out if I am protected?**

**Be sure to check your plan documents or contact your health plan to find out if you are protected by this law.** When you schedule a medical service, ask your health care provider if they are in-network. Insurers are required to tell you (on their websites or on request) which providers are in their networks. Hospitals and other health care providers also must tell you (on their websites or on request) which insurance plans they contract with as in-network providers. Whenever possible, you should use in-network providers for your health care to avoid paying more.

After you receive medical services, your health plan will send you an “Explanation of Benefits” (EOB) that will tell you what you must pay the provider. Save the EOB and check that any bills you receive are not more than the amount listed.

**When you cannot be balance billed:**

If the new law applies to your health plan, an out-of-network provider can no longer balance bill or collect more than your plan’s in-network cost-sharing amounts for either (1) emergency care or (2) when you receive lab or professional services (like surgery, anesthesiology, pathology, radiology, and hospitalist services) at an in-network facility.

**What should I know about these situations?**

Your cost-sharing amount will be based on what your plan usually pays an in-network provider in your area. These payments must count toward your in-network deductible and out-of-pocket limit. If the out-of-network provider collects more than this from you, the provider must refund the excess with interest.

*Exception:* If you have a high deductible health plan with a Health Savings Account (HSA) or a catastrophic health plan, you must pay any additional amounts your plan is required to pay to the provider, up to the amount of your deductible.

**What if I am billed too much?**

If you are billed an amount more than your payment responsibility shown on your EOB, or you believe you’ve been wrongly billed, you can file a complaint with the State Corporation Commission’s (SCC) Bureau of Insurance.

To contact the SCC for questions about this notice visit: [scc.virginia.gov](http://scc.virginia.gov) or call: 1-877-310-6560.