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Your Rights and Protections Against Surprise Medical Bills are protected by Federal and State law.

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"?
When you see a doctor or other health care provider who is not a part of your health insurance's network, 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 healthcare 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 total amount charged for a service. This is called "balance billing." This amount is likely more than your 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 any unexpected bill you may receive. This often happens when you are unable to control who is involved in your care and need to be treated for a medical emergency in a hospital setting. Hospitals do not always employ the required medical specialists needed to care for a specific patient's medical condition. The NSA specifically acknowledges that this situation can lead to times in which a patient may be admitted to a hospital that is in their health insurance's network but may require care by a medical specialist who is not in their health insurance's network (AKA out-of-network).

You're 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 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 balance 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 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. Additionally, you may decide to choose an in-network provider.

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:

- o Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
- o Cover emergency services by out-of-network providers.
- o 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.
- o Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

Virginia law does not allow a patient to waive and does not allow a provider to ask a patient to waive their rights to balance billing protections for services.

If you think you've been wrongly billed, contact the federal agencies responsible for enforcing the federal balance billing protection law at **1-800-985-3059**.
You can also file a complaint with the Virginia State Corporation Commission Bureau of Insurance by calling **1-877-310-6560** or visiting the website at **https://scc.virginia.gov/pages/File-Complaint-Consumers.**

Please visit **www.cms.gov/nosurprises/consumers** for more information about your rights under federal law.

Consumers covered under a) fully insured policy issued in Virginia, (b) the Virginia state employee health benefit plan; or (c) a self-funded group that opted-in to the Virginia protections are also protected from balance billing under Virginia law. For more information about your rights, visit **scc.virginia.gov/pages/Balance-Billing-Protection**.

At Virginia Child Neurology Specialists, we welcome you to explore our website for information on our fee schedules or call our office with any questions regarding billing or services. Please keep in mind that Government-sponsored health plans such as Medicare, Medicaid, the Children's Health Insurance Program, TRICARE, and Veterans' Affairs Health Care have other protections against medical billing that you can review on their websites.

Availability of a Good Faith Estimate

Under the law, health care providers need to give **patients who don’t have certain types of health care coverage** or who are not using certain types of health care coverage an estimate of their bill for health care items and services before those items or services are provided.

- You have the right to receive a Good Faith Estimate for the total expected cost of any healthcare items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- If you schedule a healthcare item or service at least 3 business days in advance, make sure your healthcare provider or facility gives you a Good Faith Estimate in writing within 1 business day after scheduling. If you schedule a healthcare service at least 10 business days in advance, make sure your healthcare provider or facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask any healthcare provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after you ask.
- If you receive a bill that is at least $400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate and the bill.

For questions or more information about your right to a Good Faith Estimate, visit **www.cms.gov/nosurprises/consumers**, email **FederalPPDRQuestions@cms.hhs.gov**, or call **1-800-985-3059**.

By calling our office, we can make an estimate available to you. Our fee schedules and list of approved insurances are also available at **vacns.com**.