Your 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 health care 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 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 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 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 are never 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.

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 Idaho Department of Insurance by visiting the department's website at doi.idaho.gov/nosurprises or by calling the Consumer Affairs section at 1-208-334-4319 or toll-free in Idaho at 1-800-721-3272.

Notice to Self-Pay Patients – Right to a Good Faith Estimate of Charges:

If you are uninsured or if you choose not to use your health insurance for a scheduled service, you are considered a "self-pay" patient under federal law. Under the No Surprises Act, you are entitled to receive a "Good Faith Estimate" ("GFE") of the expected charges for your health care services.

If you schedule an appointment or service less than three (3) business days in advance, a GFE is not automatically required. You may request one and VHC will make reasonable efforts to provide one before your scheduled appointment.

If you schedule an appointment or service more than three (3) business days in advance the VHC will provide you with a GFE of expected charges no later than one (1) business day after the date of scheduling.

The GFE reflects the expected charges for services that are reasonably anticipated to be provided by the VHC during your outpatient office visit. The estimate is not a guarantee of final charges. Actual charges may differ if additional or different services are medically necessary based on your condition or treatment needs. If you receive a bill that is substantially higher than your GFW, you may have the right to initiate a federal patient-provider dispute resolution process. Substantially higher means amounts greater than $400.00.

Please contact our office if you would like to request a GFE or have questions about self-pay pricing for outpatient office visits.

Visit www.cms.gov/nosurprises/consumers and www.cms.gov/medical-bill-rights for more information about your rights under federal law. Visit https://doi.idaho.gov/consumers/health-insurance for more information about your rights under Idaho state law.