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, 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" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the total 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 schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You're protected from balance billing for:

Emergency services

Suppose you have an emergency medical condition and get emergency services from an out-of-network provider or facility. In that case, the most the provider or facility may 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 a 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 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 to be balanced 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.

New Jersey law also protects you from being billed for inadvertent out-of-network services (services at an in-network facility provided by out-of-network providers) in an amount in excess of your in-network cost-sharing amount (i.e., the amount your deductible, copayments, or coinsurance would have been if the same services were provided on an in-network basis).

You're never required to give up your protection 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 the following protections:

- You are 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 directly to out-of-network providers and facilities
- 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 think you've been wrongly billed,

Contact 1-833-335-4010 to reach the Customer Service desk for Virtua Health.

Contact the Centers for Medicare & Medicaid Services, Department of Health and Human Services at 1-800-985-3059 or visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Visit https://www.state.nj.us/dobi/index.html for more information about your rights under New Jersey State Law.

To file a complaint, contact the New Jersey Department of Banking and Insurance at 609-292-7272 or file an online complaint at https://www.state.nj.us/dobi/consumer.htm.