

## GOOD FAITH ESTIMATE

Effective January 1, 2022, a ruling went into effect called the "No Surprises Act" which requires practitioners to provide a "Good Faith Estimate" to individuals who are uninsured or utilize self-pay.

**The Good Faith Estimate** (referred to throughout this document as "GFE") works to show the cost of items and services that are reasonably expected for your health care needs for an item or service, a diagnosis, and a reason for mental health services. The estimate is based on information known at the time the estimate was created. The GFE does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur and will be provided a new GFE should this occur. If this happens, federal law allows you to dispute (appeal) the bill if you and your provider have not previously talked about the change and you have not been given an updated GFE.

**Under Section 2799B-6 of the Public Health Service Act (PHSA)**, health care providers and health care facilities are required to inform individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing of their ability, upon request, or at the time of scheduling health care items and services to receive a GFE of expected charges.

**Note:** The PHSA and GFE do not currently apply to any individuals who are using insurance benefits, including "out of network benefits" (i.e., submitting superbills to insurance for reimbursement).

**Timeline requirements:** Providers are required to provide a GFE of expected charges for a scheduled or requested service, including items or services that are reasonably expected to be provided in conjunction with such scheduled or requested item or service. That estimate must be provided within specified timeframes:

- If the service is scheduled at least 3 business days before the appointment date: no later than 1 business day after the date of scheduling;
- If the service is scheduled at least 10 business days before the appointment date: no later than 3 business days after the date of scheduling; or
- If the uninsured or self-pay individual requests a GFE (without scheduling the service), no later than 3 business days after the date of the request. A new GFE must be provided, within the specified timeframes if the individual reschedules the requested item or service.

**All Good Faith Estimates will include common services and corresponding billing codes as well as diagnosis codes and estimated timeframe.**

**As every individual's mental health treatment length is unique, you and your provider will continue to assess the frequency of services and work together to determine treatment length and update the good faith estimate as needs arise.**

# 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 facility, 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.

Insurers are required to tell you which providers and facilities are in their networks. Providers and facilities must tell you with which provider networks they participate. This information is on the insurer's, provider's or facility's website or on request.

## 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 deductibles, copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services at the same facility that 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 facility**

When you get services from an in-network facility, 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, laboratory, surgeon and assistant surgeon services, and professional ancillary services such as anesthesia, pathology, radiology, neonatology, hospitalist, or intensivist services. These providers **can't** balance bill you and **can't** ask you to give up your protections not to be balance billed.

If you receive 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.**

**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 in-network deductible and in-network out-of-pocket limit.

**If you believe you've been wrongly billed**, you may call the federal agencies responsible for enforcing the federal balance billing protection law at: **1-800-985-3059** and/or file a complaint with the Virginia State Corporation Commission Bureau of Insurance at: [scc.virginia.gov/pages/File-Complaint-Consumers](https://scc.virginia.gov/pages/File-Complaint-Consumers) or call **1-877-310-6560**.

Visit [cms.gov/nosurprises](https://cms.gov/nosurprises) for more information about your rights under federal law.

Consumers covered under (i) a fully-insured policy issued in Virginia, (ii) the Virginia state employee health benefit plan; or (iii) a self-funded group that opted-in to the Virginia protections are also protected from balance billing under Virginia law. Visit [scc.virginia.gov/pages/Balance-Billing-Protection](https://scc.virginia.gov/pages/Balance-Billing-Protection) for more information about your rights under Virginia law.

**For any questions regarding this notice or billing, please reach out to the Admin & Billing Supervisor, LaTonya Coley via email at: [lcoley@childsavers.org](mailto:lcoley@childsavers.org) or 804-591-3905.**