DR. STEPHEN C. BROWN
ORAL & MAXILLOFACIAL SURGERY™

Your Rights and Protections Against Surprise Medical Bills
Virginia

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 surprise 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 dentist, orthodontist, or oral maxillofacial surgeon, 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 or providers that haven't signed a contract with your health or dental plans to provide in-network 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 in an emergency service. 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 bills could cost thousands of dollars depending on the procedure or service.

YOU'RE PROTECTED FROM SURPRISED 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 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 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, most of those providers may bill you 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.

Surgical center

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.

If you get other types of services at an in-network hospital or ambulatory surgical center, out-of-network providers **can't** balance bill you unless you give written consent and give up your protections.

VIRGINIA LAW

Virginia state law may protect you from "balance billing" when you receive:

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 healthcare professional at an in-network hospital, ambulatory surgical center or other healthcare facility.

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 the State Corporation Commission website or call (877) 310-6560

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THESE 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 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 think you've been wrongly billed, visit https:// www.cms.gov/nosurprises/consumers for more information about your rights under federal law. The federal phone number for information and complaints is 1-800-985- 3059.

You may also contact Virginia State Corporation Commission's (SCC) Bureau of Insurance. To contact the SCC for questions about this notice visit the State Corporation Commission website or call (877) 310-6560.