Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, 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.

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 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, the most those providers may 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 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.

The similar Massachusetts state law ***An Act Promoting a Resilient Health Care System that Puts Patients First*** **("*Patients First*")** offers similar protections. As a patient or potential patient, we must inform you either verbally or in writing whether we take patients in your health insurance plan, when you are scheduling a hospital stay, medical procedure, or health care service related to a non-emergency medical condition.

After we give you this information the first time, you can choose not to receive the information again when you schedule follow-up hospital stays, medical procedures, or health care services with that same provider.

- You can request the following information: You have the right to know how much your health insurance plan will pay for that hospital stay, medical procedure, or health care service. This is called the "allowed amount." You also have the right to know what if any facility fees you will be charged for that hospital stay, medical procedure, or health care service. Facility fees are sometimes charged when a procedure is done at a hospital or clinic, rather than a doctor's office. You must be provided this information within two business days of your request.
- If a health care provider is unable to tell you a specific amount (because they cannot predict what specific treatment will be needed), they must tell you the estimated maximum amount that your insurance will pay and tell you about any facility fees.
- You can get additional information about out-of-pocket costs (such as deductibles, co-pays and co-insurance) from your health insurance plan's toll-free number or website.

If we do not accept your health insurance ('out-of-network), we must verbally inform you of this at the time we schedule your appointment and also give you written notice as well.

- We must tell you about any expected costs for you, at the time you schedule your appointment.
- We must tell you that you will be responsible for any costs for you which are not covered by your health insurance plan.
- We must inform you that you may be able to get the hospital stay, medical procedure or health care service at a lower cost from another health care provider, who participates in your health insurance plan.

The law also has requirements for when your health care provider refers you to another health care provider. This is called a "referral."

We are required to:

- Tell you if the provider you are referred to is part of the same "provider organization" as your provider. This would mean that the two providers are in same physician organization, physician-hospital organization, independent practice association, provider

network, accountable care organization or another organization that contracts with health insurance companies.
- Give you enough information about the provider you are referred to so that you can figure out if this provider is "in network," which means the provider is covered by your insurance plan.

Your health insurance plan has a toll-free telephone number and website where you can find out: (1) if a provider is in your network (2) the estimated or maximum "allowed amount" or charge for a hospital, medical procedure or health care service, and (3) the estimated amount you will be responsible to pay for a hospital stay, procedure or service.

- Tell you that if the provider you are referred to is not in-network, there may be out-of-network costs that apply.
- Tell you to confirm whether the provider you are referred to participates in your health insurance plan by calling the provider and/or your health plan before making an appointment or agreeing to use their services.

If your health care provider is directly scheduling, ordering, or arranging health care services for you with another provider, your provider must:

- Verify whether the provider you are referred to is in-network for your plan.
- Notify you if the provider you are referred to is not in-network or that your provider cannot verify whether or not the provider you are referred to is in-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 deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact our office's Patient Accounts Department at 978-818-6475. You make also contact the No Surprises Help Desk at 1-800-985-3059 or go to https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing to submit a complaint online.

Massachusetts Patients First Law Contact information: If you have not received any of these required notifications from your health care provider, you may submit a complaint, in writing, to the health care provider's professional licensing board, or in the case of a licensed facility, to the Massachusetts Department of Public Health.

To file a complaint with the Board of Registration in Medicine's (BORIM) Consumer Protection Division:

- All complaints and reports to BORIM: https://www.mass.gov/submit-a-complaint
- Patient or patient representative complaints against physicians: https://www.mass.gov/service-details/submit-a-complaint-against-a-physician

Visit www.cms.gov/nosurprises for more information about your rights under federal law.
Visit www.mass.gov/dph for more information about your rights under the Massachusetts "Patient First" Act.

By signing below, I acknowledge that I was provided the 'Your Rights and Protections Against Surprise Medical Bills' informational handout which informs me of all my federal rights under the "No Surprises Act"' as well as my state rights under the Massachusetts 'Patients First Act".

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Signature (Patient or Authorized Person) Date