

Your Rights and Protections Against Surprise Medical Bills in Massachusetts

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

Under the federal No Surprises Act (NSA), 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 group or individual health insurance policies or group health 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 balance 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 “ancillary service 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.

Massachusetts Law

Under the Massachusetts law, upon scheduling an admission, procedure or service which are **not** provided to treat an emergency medical condition (collectively referred in this notice as an "Episode of Care"), a health care provider is required to disclose whether the provider is participating in the patient's health benefit plan.

If the health care provider is participating in the patient's health benefit plan, the provider is required to inform the patient that they may request disclosure of the allowed amount (i.e., the contractually agreed-upon maximum amount paid to the health care provider under the insurance policy or health plan) and inform the patient that on how they may obtain information about any applicable out-of-pocket costs from the patient's health benefit plan.

If the health care provider does not participate in the patient's health benefit plan, the provider is required at the time of scheduling a Episode of Care, (i) the charges the patient should expect to receive, (ii) inform the patient that the patient will be responsible for the any charges not covered by the patient's health benefit plan and (iii) inform the patient that they may be able to obtain the medical treatment being sought at a lower cost form a health care provider who participates in the patient's health benefit plan.

For patients that are not receiving treatment for an emergency medical condition, health care providers are required to determine if they participate in a patient's health benefit plan and, if the Episode of Care is scheduled more than 7 days in advance, the provider must provide this notice verbally and in writing at least 7 days in advance; and, if the Episode of Care is scheduled less than seven days in advance, provide the patient with verbal notice not less than two days in advance and with written notice upon the patient's arrival for the Episode of Care. If the healthcare provider is out-of-network and does not provide these notifications, the provider is prohibited from billing the patient except for any applicable copayment, coinsurance or deductible under the terms of the patient's insurance plan.

Further, a health care provider that is referring a patient to another provider is required to disclose the possibility that (i) the provider to whom the patient is referred may be not be participating in the patient's health benefit plan; (ii) applicable out-of-network rates under the patient's plan may apply and (iii) that the patient has the opportunity to verify whether the provider participates in the health benefit plan prior to making the or agreeing to use the use the provider. If the health care provider directly schedules the Episode of Care with the referring provider, the provider must, prior to scheduling , verify the in-network or out-of-network status of the provider or tell the patient that this information could not be verified.

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:
 - o Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - o Cover emergency services by out-of-network providers.
 - o 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.
 - o 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 the Centers for Medicare and Medicaid Services by phone at 1-800-985-3059.

You may also contact the Massachusetts Division of Insurance <https://www.mass.gov/how-to/filing-an-insurance-complaint> or by emailing CSSComplaints@mass.gov