BOSTON MEDICAL CENTER
HEALTHNet PLAN

BMC HealthNet Plan
ConnectorCare/Qualified Health Plan Members

Your Rights and Protections Against Surprise Medical Bills

When you get out-of-network emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, in most cases you are protected under federal law from balance billing. In these cases, you shouldn't be charged more than BMC HealthNet 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 cost-sharing, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see an out-of-network provider or visit a health care facility that is out-of-network.

"Out-of-network" means providers and facilities that haven't signed a contract with BMC HealthNet Plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what the Plan pays and the full amount the provider charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and does not count toward your deductible or annual out-of-pocket maximum.

"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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

Under a new federal law effective January 1, 2022, you're 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 they can bill you is the 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 certain services you may get after you're in stable condition, unless you give written consent to the out-of-network provider and/or facility 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 can bill you is the 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 types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give these providers written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in the Plan's network.

Also, under Massachusetts law, out-of-network providers are required to make certain disclosures and give you certain notices. For example, out-of-network providers may have to tell you in advance of a scheduled service that they are not in the Plan's network, the charges for the scheduled service, that you will be responsible for the charge not covered by the Plan, and that you may be able to obtain the service at a lower cost from an in-network provider. This state law also limits out-of-network balance billing in certain circumstances. For more information, see Mass. Gen. Laws. Ch. 111, section 228.

When balance billing isn't allowed, you also have these federal protections:

- You're only responsible for paying your share of the cost (like copayments, coinsurance, and deductible that you would pay if the provider or facility was in-

network). The Plan will pay any additional costs to out-of-network providers and facilities for covered services directly.

- The Plan generally 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 cost-sharing amount you pay for out-of-network emergency services or certain other out-of-network services toward your in-network deductible and out-of-pocket maximum.

If you believe you've been wrongly billed

The Plan is awaiting contact information for the state agency responsible for enforcing *the federal and/or state balance or surprise billing protection laws and will update this Notice with this contact information once it is received*. The federal phone number for information and complaints is: 1-800-985-3059. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.