

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, including a 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.

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](#), 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 that haven't signed a contract with your health plan to provide 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. 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.

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 they can bill you is your 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 services you may get after you are 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, including a hospital or ambulatory surgical center: When you get services from an in-network facility, including a hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can 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 types of 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 are never required to give up your protections from balance billing under federal and New Hampshire law. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

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.

New Hampshire Law

Consistent with the federal No Surprises Act (as described in this notice), New Hampshire law prohibits anesthesiologists, radiologists, pathologists, and emergency medicine providers from billing commercially insured patients covered by a managed care plan who are treated at an in-network hospital or ambulatory surgery center for more than the in-network cost-sharing amount (i.e., even if the anesthesiologist, radiologist, pathologist, or emergency medicine provider is out-of-network).

- **If you have questions about your insurance coverage or potential out-of-pocket costs**, please contact our Financial Counselors at DFCIAccessFIO@partners.org or **617-582-9820**. If you have **questions about your bill**, please contact Customer Service at dfcicustomerservice@partners.org or **617-632-3795**.
- **If you think you've been wrongly billed or want more information about your rights and protections**, you may call the No Surprises Help Desk at 800-985-3059, or visit www.cms.gov/nosurprises/consumers.
- **If you have a commercial managed care plan regulated by the New Hampshire Department of Insurance and think you've been wrongly billed or want more information about your rights and protections**, contact the New Hampshire Department of Insurance at 603-271-2261, or visit www.nh.gov/insurance/complaints/index.htm.