



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 surprise billing or balance billing. In these cases, you should not 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, 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 healthcare 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 for the difference between what your insurance has agreed to pay. This can happen when you can't control who is involved in your care. For example, when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly /unknowingly 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 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 providers can't balance bill you and/or 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 are also not required to get care out-of-network. You can choose a provider or facility in your plan's network.

Your provider must notify you if you are being referred to another provider in the same practice or facility who has out-of-network provider status with your health plan.

WHEN BALANCE BILLING IS NOT 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 were 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.

Contact Harvard University Health Services Patient Accounts at (617) 496-8700 or billing@huhs.harvard.edu if you have questions about your bill.

YOU HAVE THE RIGHT TO RECEIVE A "GOOD FAITH ESTIMATE" EXPLAINING HOW MUCH YOUR CARE WILL COST

Under federal law, healthcare providers are required to give patients who do not have or are not using certain types of healthcare coverage an estimate of their bill for non-emergency healthcare items and services before those items or services are provided.

You have the right to receive a good faith estimate (GFE) for the total expected cost of any non-emergency healthcare items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, etc. However, in some cases, HUHS may not be able to predict specific charges. In these circumstances, HUHS will provide the estimated maximum cost for the visit, procedure, or service.

Under federal law, if you receive a bill that is at least \$400 or more for a provider or facility than your good faith estimates from that provider or facility, you can dispute the bill.

For questions or more information concerning your right to a good faith estimate, visit cms.gov/medical-bill-rights.

If you believe you've been wrongly billed, you may contact the No Surprises Help Desk at (800) 985-3059 or the Massachusetts Attorney General's Office at (888) 830-6277. Visit cms.gov/nosurprises for more information about your rights under federal law.

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