YMCA of Metro North Disclosure Notice-Patient Protections Against Surprise Billing

For all current and prospective YMCA of Metro North employees that participate in the employer sponsored group health care plan- CIGNA.

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.

Massachusetts law also protects you from balance billing when receiving emergency services if you have HMO coverage and if you have PPO coverage and did not have a reasonable opportunity to utilize a preferred provider.

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.

Additionally, Massachusetts law protects you from being balance billed when receiving covered services from an out-of-network provider:

- when you did not receive advance notice that the provider was out-of-network;
- when the medically necessary, covered services are not available in-network; or
- at an in-network facility and you did not have a reasonable opportunity to choose an in-network provider.

These protections apply to patients with coverage through a health maintenance organization (HMO) or a preferred provider organization (PPO) and only require you to pay the amount required for in-network services.

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:

- The Centers for Medicare & Medicaid Services (CMS) at 800-985-3059 or online at www.cms.gov/nosurprises.
- The Massachusetts Attorney General's office at 888-830-6277 or online at www.mass.gov/how-to/file-a-health-care-complaint.
- The Massachusetts Division of Insurance, Consumer Services Unit at 617-521-7794 or online at www.mass.gov/how-to/filing-an-insurance-complaint.

Visit **https://www.cms.gov/nosurprises** for more information about your rights under federal law.

Visit **https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter111/Section228** for more information on your rights under MA state law.