Major League Baseball Players Benefit Plan

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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 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, like 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 the Plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with Aetna, the Plan's network provider, 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 charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service. The balance billed amount does not count toward the 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.

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 coinsurance and deductibles). 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.

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 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 written consent and give up your protections against balance billing.

You're never 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.

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

- You are only responsible for paying your share of the cost (like the coinsurance and deductibles 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 directly.

- Generally, the Plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization"). (The Plan does not require prior authorization for any services.)
    - 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 think you've been wrongly billed, contact the U.S. Department of Health and Human Services ("HHS") by calling 1-800-985-3059 or visiting https://www.cms.gov/nosurprises/consumers. Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

You also may call the Benefit Plan Office at 800-669-2255 if you have any questions.