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 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 the provider and the full amount charged by the provider. 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'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 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're in a 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 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 balanced 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'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 your plan's network.

Maryland-specific balance billing protections

If you are in a Health Maintenance Organization (HMO) governed by Maryland law, you may not be balance billed for services covered by your plan, including ground ambulance services.

If you are in a PPO or EPO governed by Maryland law, hospital-based or on-call physicians paid directly by your PPO or EPO (assignment of benefits) may not balance you for services covered under your plan and can't ask you to waive your balance billing protections.

If you use ground ambulance services operated by a local government provider who accepts an assignment of benefits from a plan governed by Maryland law, the provider may not balance bill you.

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

- You are only responsible for paying your share of the cost (the copayments, coinsurance, and deductible that you would pay if the provider or facility was innetwork). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Your health plan generally:
    - 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.

If you believe you've been wrongly billed, you may contact the Health Education and Advocacy Unit (HEAU) of Maryland's Consumer Protection Division:

Health Education and Advocacy Unit
Office of the Attorney General 200
St Paul Place, 16th Floor Baltimore,
Maryland 21202
Phone: (410) 528-1840 or toll free 1 (877) 261-8807
En Español: 410-230-1712
Fax: (410) 576-6571 heau@oag.state.md.us
Website: https://www.marylandattorneygeneral.gov/Pages/CPD/HEAU

If you believe your health plan processed your claim incorrectly, you may contact the Maryland Insurance Administration:

Maryland Insurance Administration
Life and Health Complaints Unit 200
St Paul Place, Suite 2700 Baltimore,
Maryland 21202
Phone: (410) 468-2000 or toll free 1-(800) 492-6116
Fax: (410) 468-2260
Website: http://www.insurance.maryland.gov

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