Your Rights and Protections Against Surprise Medical Bills

Understanding the cost of your care is important. We are here to help you understand your upcoming healthcare costs and all assistance programs available to you so you can plan for your care.

No Surprises Act Overview

Beginning January 1, 2022, the federal No Surprises Act protects patients from surprise medical bills from an out-of-network provider, out-of-network facility, or out-of-network air ambulance provider. The law aims to help both insured and uninsured patients understand and plan for health care costs in advance of care and to minimize unforeseen — or surprise — medical bills.

- Insured patients are protected from receiving surprise medical bills resulting from out-of-network care at an in-network facility for emergency services and for certain scheduled services without prior patient consent.
  Individuals with Medicare, Medicare Advantage, Medicaid, Indian Health Services, Veteran Affairs health care, or TRICARE insurance plans are not covered under the No Surprises Act because these federal insurance programs have existing protections in place to minimize large, unforeseen bills.
- Uninsured patients or patients who are not using insurance to pay for their care have a right to understand the costs related to their care. Providers are required to provide a good faith estimate of their potential bill for medical services (when scheduled at least three days in advance).

What is “balance billing” (sometimes called “surprise billing”)?

When you get emergency care by an out-of-network provider or facility or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance 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” describes providers and facilities that have not 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 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 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.

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 **cannot** 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 **cannot** 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. You also are not 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 service 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 bill you for services covered under you 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.

You also have these protections:

- You're 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.
- Generally, your health plan 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 in-network deductible and out-of-pocket limit.

If you think you have 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
  Email: heau@oag.state.md.us
  Website: https://www.marylandattorneygeneral.gov/Pages/CPD/HEAU

If you think 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

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

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