

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 is not 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 annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you cannot 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 cannot 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 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 care out-of-network. 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 bill 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.

Maryland hospitals must send an itemized bill that briefly and clearly describes each item and the amount charged. Maryland hospitals must also provide you with a summary statement of your account within 30 days after you are discharged. You may request an itemized statement of your account up to one year after discharge, and the hospital is required to provide it to you within 30 days.

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 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 Health Education and Advocacy Unit (HEAU) of Maryland's Consumer protection Division, Office of the Attorney General:

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: <http://www.marylandattorneygeneral.gov/Pages/CPD/HEAU> | You may also contact the U.S. Department of Health & Human Services at 1-877-696-6775.

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, MD 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.

Visit marylandattorneygeneral.gov or insurance.maryland.gov for more information about your rights under Maryland law.

