No Surprises Act: Billing Disclosures

Effective January 1, 2022, the federal No Surprises Act protects patients from surprise bills for emergency services and for certain non-emergency services provided by out-of-network providers at in-network facilities. If these protections apply, patients are only liable for in-network cost-sharing amounts. Maryland law also provides protections from surprise bills.

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 health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, or a deductible. You may also have other costs or have to pay the full 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 a provider or facility hasn't signed a contract with your health plan. Out-of-network providers may be allowed to bill you for the difference in your plan's benefits and the full cost of a service. This is balance billing. A balance bill is likely more than your in-network costs for a service and may not apply to your annual out-of-pocket limit.

A surprise bill 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 get emergency services from an out-of-network provider or facility, the provider or facility may not bill you more than your plan's in-network cost-sharing amount (such as copayments and coinsurance). They **can't** balance bill you 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, some 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.

Maryland Protections

Maryland law also provides protections from surprise bills. If you are covered by a Maryland health maintenance organization (HMO), an out-of-network provider can't balance bill you for covered health care services. You are only liable for your plan's applicable cost-sharing amount.

For Maryland preferred provider organizations (PPO), an on-call physician or hospital-based physician who is out-of-network can't balance bill you for covered health care services (and you are only liable for your plan's applicable cost-sharing amount) **if** both you and the provider agree to an assignment of benefits for covered services. An "assignment of benefits" is a legal contract that allows your health plan to pay your provider directly for covered 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 No Surprises Help Desk operated by the U.S. Department of Health and Human Services (HHS) at 1-800-985-3059, or visit **https://www.cms.gov/nosurprises** for more information about your rights under federal law.
- The Maryland Insurance Administration, the State Insurance Commissioner at 410-468-2000, or visit www.insurance.maryland.gov for more information about your rights under Maryland laws.