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—also called surprise billing?

When you see a doctor or other healthcare 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 healthcare facility that isn't in your health plan's network.

Out-of-network describes providers and facilities that haven't 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 can't control who is involved in your care—for example when you have an emergency or schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

When are members protected from balance billing?

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 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 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.

For Maryland residents

If you are covered by an insured Maryland preferred provider organization (PPO) health benefits contract, an out-of-network on-call physician or hospital-based physician may accept assignment of benefits from you for covered services. If you agree to assign benefits to the out-of-network physician, you are only responsible for your plan's deductible or cost-sharing amounts (such as copayments and coinsurance). The out-of-network physician may not balance bill you for the covered services.

If you are covered by a Maryland health maintenance organization (HMO) health benefits contract and are referred to an out-of-network provider in Maryland by an in-network provider for covered services, you are only responsible for your plan's in-network deductible, copay or coinsurance cost-sharing amounts. The out-of-network provider may not balance bill you for the covered services.

For Virginia residents

Consumers covered under (i) a fully-insured policy issued in Virginia, (ii) the Virginia state employee health benefit plan; or (iii) a self-funded group that opted-in to the Virginia protections are also protected from balance billing under Virginia law.

For care received from a non-participating provider, the member is responsible for any applicable deductible, copayment or coinsurance amounts stated in the Virginia insured member's health benefits contract. For the following services, you may not be balance billed by the provider for covered services:

- Emergency services from an out-of-network hospital, or an out-of-network doctor or other medical provider at a hospital
- Non-emergency surgical or ancillary services from an out-of-network lab or healthcare professional at an in-network hospital, ambulatory surgical center or other healthcare facility

For all members

You are 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.

When balance billing is not allowed, what other protections does a member have?

- 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 have been wrongly billed, you may contact:

Maryland: agcomplaints.mia@maryland.gov or 410-468-2270

Virginia: askaquestion@scc.virginia.gov or 877-310-6560

Washington, D.C.: disbcomplaints@dc.gov or 202-727-8000

Federal: Department of Labor, Employee Benefits Security Administration 202-693-8673 or Department of Health and Human Services 800-985-3059

For more information: https://www.cms.gov/nosurprises

Virginia: Visit scc.virginia.gov/pages/Balance-Billing-Protection for more information about your rights under Virginia law.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.