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 facility, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes 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.

Insurers are required to tell you which providers and facilities are in their networks. Providers and facilities must tell you with which provider networks they participate. This information is available on the insurer's, provider's or facility's website or on request.

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 deductibles, 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 facility**—When you get services from an in-network facility, 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, laboratory, surgeon and assistant surgeon services, and professional ancillary services such as anesthesia, pathology, radiology, neonatology, hospitalist or intensivist services. These providers **can't** balance bill you and **can't** ask you to give up your protections not to be balance billed.

CareFirst CAA Surprise Billing Member Notice (1/22)

If you receive 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 consumers**—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 can't 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 can't balance bill you for the covered services. Visit https://insurance.maryland.gov/Consumer/Pages/Federal-No-Surprises-Act.aspx for more information about your rights under Maryland Law.
- **For Virginia consumers**—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. Visit scc.virginia.gov/pages/Balance-Billing-Protection for more information about your rights under Virginia law.

*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.*

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 in-network deductible and out-of-pocket limit.

***If you believe you have been wrongly billed**, you can call the federal agencies responsible for enforcing the federal balance billing protection law at **1-800-985-3059** and/or file a complaint with your local bureau of insurance:*

- Maryland: agcomplaints.mia@maryland.gov or 410-468-2270
- Virginia: scc.virginia.gov/pages/File-Complaint-Consumers or 1-877-310-6560
- Washington, D.C.: disbcomplaints@dc.gov or 202-727-8000

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