the need for you to pay the provider in full and then seek reimbursement of the allowed amount under your policy. Keep in mind, however, that you may still owe the provider a copayment, coinsurance, and the balance between the allowed amount and the provider's billed amount; the balance of the bill. Ambulance companies can also agree to an assignment of benefits. You may ask the provider for such an agreement or the provider may ask you to sign one.

13. What if I have to go to the hospital and can't control who treats me?

Whether the visit to the hospital is planned or not, you will not always be able to choose the provider who provides services and you may be treated by a hospital-based physician or an on-call physician for all or part of your treatment. Hospital-based physicians are doctors who work directly for the hospital or work for a private practice group that has a contract with the hospital to provide services. On-call doctors are doctors who are permitted ("have privileges") to work at a hospital but do not have a contract with it, and are on-call to provide services to patients who do not have their own providers. All types of physicians work as hospital-based or on-call doctors including, for example, emergency room doctors, anesthesiologists, and radiologists.

If your PPO plan is subject to Maryland law, and you and the hospital-based or on-call doctor agree to an assignment of benefits, then the plan will send the payment to the doctor. The hospital-based or on-call physician will be paid based on state law and cannot balance bill you. But you will still have to pay any applicable deductible, copayment, and coinsurance.

What do I need to know about assigning my benefits to an out-of network provider? If you have a PPO plan, and an out-of-network physician, other than an on-call physician or hospital-based physician, that agrees to accept an assignment of benefits from you, the doctor is required to provide the following notice to you before providing services:

- Your doctor is not a part of your health insurer's network. You may pay more for the services provided by your doctor because:
  - Your doctor's charge may be higher than the amount your health insurer will pay and, if so, you may be required to pay the difference; and
  - Your coinsurance, deductible and out-of-pocket maximum may be higher because your doctor is not in your health insurer's network.
  - Your doctor may charge you for services not covered under your health insurance contract.
- Your doctor will provide you with the following information before performing the services for you:
  - An estimate of the cost of the services;
  - Any payment terms that apply; and
  - Whether your doctor will charge you interest on any unpaid balance, and the amount of the interest, if any.

You will also be asked to sign the following statement:

I, [patient's name] received the information above and authorize my health insurer to reimburse my doctor directly for the services provided [today's date].

14. What if I am transported by ambulance?

Ambulance services that are owned, operated, or under the jurisdiction of a political subdivision of the state (such as a county or town), or a volunteer force company or rescue squad, or have a contract with a political subdivision to provide services, can also seek an assignment of benefits. Ambulance companies can agree to an assignment of benefits but are not required by law to make the same disclosure as doctors who are not hospital-based physicians or on-call physicians.

15. How Can I Appeal When My Insurance Company Denies Coverage?

Your insurance company may fully or partially deny a pre-authorization request or a claim for coverage if services are not covered by your health plan, or if it believes services are not medically necessary. For example, your insurance company may say that care is custodial but you think it is medically necessary. If you believe your request for pre-authorization or claim has been wrongly denied, you can file an appeal with your insurance company. The instructions for filing an appeal will be in your policy, and may also be in the Explanation of Benefits letter, or in your health plan's Summary of Benefits and Coverage.

The Health Education and Advocacy Unit of the Consumer Protection Division in the Office of the Attorney General can help you file an appeal. You can email them at heau@oag.state.md.us or call 410-528-1840 or toll free at 1-877-261-8807 Monday – Friday 9 a.m. – 4:30 p.m. You can also file your complaint online or by mail. The website to learn more is: *http://www.marylandattorneygeneral.gov/Pages/CPD/HEAU/default.aspx.*

If your health plan is subject to Maryland law, you may also be able to file a complaint with the MIA by calling 410-468-2340 or toll free at 1-800-492-6116. Generally, you must appeal the decision through your health plan's appeal process before filing a complaint with the MIA. But in some situations, you may be able to file a complaint with the MIA even if you have not completed your health plan's appeals process. To learn more, go to: *http://insurance.maryland.gov/Consumer/Pages/FileAComplaint.aspx.*

If your health plan is not subject to Maryland law, you may still have the right to an external review of the health plan's decision. You should read your policy for instructions about how to request this, or contact the HEAU for help in filing the request.

For more information, visit the MIA website at *www.insurance.maryland.gov*

The Maryland Insurance Administration (MIA) is the state agency that regulates the business of insurance in the State of Maryland. If you have a question about insurance or experience a problem, contact the MIA at 800-492-6116 or visit our website at *www.insurance.maryland.gov.*

Persons with disabilities may request this document in an alternative format. Requests should be submitted in writing to the Chief, Communications and Public Engagement at the address listed below.

Maryland
INSURANCE ADMINISTRATION

200 St. Paul Place, Suite 2700
Baltimore, MD 21202
410-468-2000
800-492-6116
800-735-2258 TTY
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www.facebook.com/MdInsuranceAdmin
www.twitter.com/MD_Insurance
www.instagram.com/marylandinsuranceadmin

(10/22)

FREQUENTLY ASKED QUESTIONS TO HELP YOU UNDERSTAND YOUR HEALTH INSURANCE COVERAGE AND THE CLAIM PROCESS

Maryland
INSURANCE ADMINISTRATION

FREQUENTLY ASKED QUESTIONS TO HELP YOU UNDERSTAND YOUR HEALTH INSURANCE COVERAGE AND THE CLAIM PROCESS

1. Why Do I Need to Understand my Health Insurance Coverage?

Health plans cover treatment for injury or illness. Your health plan may not cover all of the health care services that you may need. For example, there may be limits on the number of visits for physical therapy or the number of days covered in a skilled nursing facility. Even if your doctor says you still need these services, if your health plan has a limit, it will not pay for the treatment beyond the limit.

You can avoid unexpected costs for health services that are not covered by your health plan by becoming familiar with the specifics of your health plan and planning a budget. When planning a budget, make sure to consider premium payments, co-payments and any charges that will not be covered by your insurance, including amounts above your policy limit.

The best way to make sure that you know what is covered by your plan is to carefully read your policy and ask your insurance company or insurance producer (also known as an insurance agent or broker) to explain anything you do not understand. Your health plan is a contract covering only specified services and supplies. If you or a family member needs treatment, you should look at the schedule of benefits in your policy to see if limits apply, or contact your insurance company or insurance producer.

2. What is an "In-Network" Provider?

These are providers that have a contract with your insurance company. If you receive covered services from an in-network provider, generally you will only need to pay your deductible and any applicable copay or coinsurance. You may not be billed for the balance by the provider.

3. What is an "Out-of-Network" Provider?

These are providers that do not have a contract with your insurance company. If you receive covered services from an out-of-network provider, the insurance company may pay only a part or none of the charges, depending upon the terms of your policy. Also, your co-payment or coinsurance may be larger than if the services had been provided by an in-network provider.

In some circumstances, you will not have to pay more for an out-of-network visit, such as in an emergency situation, when you received non-emergency treatment at an in-network facility, for air ambulance services, or if you were approved by your health plan to see an out-of-network provider for mental health services.

4. How do I Know if a Provider is "In-Network" or "Out-of-Network"?

Check your health plan's on-line provider directory or call your insurance company. You can also call your provider directly. Make sure that you know the type of health plan you have. If you are told that a provider is "participating" or "accepts" payment directly from you.

5. May I Receive Services from an "Out-of-Network" Provider?

It depends on the type of health plan you have.

- Some plans only allow you to receive services from out-of-network providers if you have an emergency, or if you do not have control over the provider you see (such as when you receive in-patient services from an out-of-network provider at an in-network hospital), or you need a certain type of specialist and there is no specialist available in the health plan's network. This is most common if you are covered under a health maintenance organization (HMO).
- Some health plans, often called Preferred Provider Organizations or PPOs, allow you to see any provider even if the provider is out-of-network.

You should review the schedule or summary of benefits for your health plan. You may also contact your employer's human resources department or your health plan for this information, or find it on the MIA's website at: *https://bit.ly/miaccp.*

6. What Will I Have to Pay if I Receive Services from an "Out-of-Network" Provider?

If you receive covered services from an out-of-network provider, and the cost of the services is more than the allowed amount your health plan pays, the provider may be allowed to bill you for the difference. In some circumstances, you may be protected from balance billing.

If you have a PPO plan, the insurance company will pay the allowed amount for covered services, but you may be responsible for a higher co-payment, deductible, and/or coinsurance. You may also be responsible for the difference between the provider's billed charge and the PPO's allowed amount (i.e. the balance bill).

You may be protected from balance billing if:

1. If your health plan is an HMO and you are approved to see an out-of-network provider that is subject to Maryland law, your HMO is not allowed to balance bill.
2. Beginning on January 1, 2023, if you are approved to see an out-of-network specialist for mental health or substance use disorder services, you cannot be balance billed.
3. The federal No Surprises Act protects you from many types of "surprise bills." In some circumstances, you will not have to pay more for an out-of-network visit, such as in an emergency situation, when you received non-emergency treatment at an in-network facility, or for air ambulance services.

7. What is an "Allowed Amount"?

The maximum amount the insurance company will use when deciding what to pay for a covered health care service. This is sometimes referred to as "payment allowance" or "negotiated rate." It is also the basis for calculating your coinsurance, which is a percentage of the allowed amount you are responsible for paying. The allowed amount will be described in your policy or certificate of coverage. It may be based on a fee schedule, a database, or a percentage of what Medicare pays. You may have to pay the difference if your provider charges more than the allowed amount and the provider is not an "in-network" provider.

8. Are Providers Allowed to Bill Me for Their Services?

If you receive covered services from an out-of-network provider, and the cost of the services is more than the allowed amount your health plan pays, the provider may be allowed to bill you for the difference. See Question 6 for more details.

9. How do I pay an "Out-of-Network" Provider?

Generally, an out-of-network provider will bill you directly for services. You would then need to file a claim with your health benefit plan in order to be reimbursed the allowed amount for your covered benefits. Under Maryland law, you have 90 days to file your claim; effective January 1, 2017, you will have two years to file a claim if it was not reasonably possible to file the claim within one year.

If the provider is willing, and your health benefit plan permits you to receive care from an out-of-network provider, you may be able to sign an "assignment of benefits" to the provider.

10. How do I Get Pre-Authorization for Healthcare Services?

To start the process of obtaining pre-authorization, call the number on the back of the patient's health insurance ID card first.

The insurance company will ask what healthcare services you would like to receive, and when appropriate, what facility you would like to use. The insurance company will tell you what documents it needs in order to decide if it will pre-authorize the healthcare service. Maryland requires that insurance companies accept a provider's Uniform Treatment Plan Form if the health plan is subject to Maryland law. A Uniform Treatment Plan Form is a document used by the provider to record the information needed by the insurance company to decide whether it will pre-authorize the requested services and/or facility.

In the case of mental health, emotional health disorder, and substance use disorder emergencies, if a patient is in imminent danger to self or others, and the determination is made by the patient's physician or psychologist and a member of the medical staff of the facility who has admitting privileges, then an insurance company cannot deny the first 24 hours of your admission based on medical necessity. Notify the insurance company as soon as possible.

For an emergency inpatient admission for treatment of a mental illness, emotional health disorder, or substance use disorder, the insurance company must make a decision on whether to pre-authorize the treatment within 2 hours of receiving the requested documents.

If the insurance company denies the request for an admission, call the Maryland Insurance Administration (MIA) at 1-800-492-6116. The MIA is available 24 hours a day for complaints in emergencies when care has not yet been rendered. In an emergency, the MIA will make a decision within 24 hours.

If the MIA does not regulate your health plan, your complaint will be sent to the agency that does regulate the plan.

An insurance company is not allowed to retaliate against a provider for filing an appeal of a denial with the insurance company or a complaint with the MIA.

The Health Education and Advocacy Unit of the Office of the Attorney General of Maryland is also available to help you with filing an appeal or complaint. Call 410-528-1840 (in Baltimore) or 1-877-261-8807.

If you believe your insurance company is not following the law, or has denied an emergency admission, call the Maryland Insurance Administration at 1-800-492-6116.

11. How much do I Have to Pay for my Annual Doctor's Visit?

You do not need to meet your deductible before you receive preventive services from an in-network provider. You also do not have to pay a co-payment or coinsurance for preventive services you receive from an in-network provider. Preventive services include screenings and immunizations, as well as other services. For a complete listing of preventive services that are covered without cost to you, check your policy, or call your insurance company. Usually, preventive services do not include diagnosis or follow-up visits and services for problems. If you visit your health care provider and discuss a health problem, you may be charged your deductible or coinsurance or co-payment for the part of the visit dealing with the problem, even if the initial reason for the visit was preventive.

12. What is an "Assignment of Benefits"?

An assignment of benefits is a legal contract used to transfer the rights to benefits under a health care plan from you (the insured) to the health care provider. If there is an assignment of benefits, the health plan will pay its portion of the fee (the benefits) directly to the provider. It eliminates

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