No Surprises Act: Your Rights and Protections Against Surprise Medical 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 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—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 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 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, certain providers 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 Insurance Administration:
(https://insurance.maryland.gov/Consumer/Documents/publications/AssignmentofBenefitsFAQ.pdf)

If you receive covered services from an out-of-network provider, and the cost of these services is more than the allowed amount, the provider may be permitted to bill you for the difference. In some circumstances, you may be protected from balance billing. For example, if you are treated by a Maryland doctor in an emergency room, the law may protect you.

You may have to pay more if you see an out-of-network provider:

• If your health plan does not cover out-of-network providers at all, you will be responsible for the entire cost of services.

• If you have a PPO plan, the provider will be paid the allowed amount for covered services but you may be responsible for a higher copayment, the deductible, 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).

Delaware:

Delaware law that protects patients from surprise bills arising from emergency department access of services and expands these protections to services received from non-network providers at in-network facilities. Out-of-network facilities rendering nonemergency services are required to provide disclosure of any out-of-network charges not covered by the insurance.

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:

o Cover emergency services without requiring you to get approval for services in advance (prior authorization).

o Cover emergency services by out-of-network providers.

o 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.

o 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, please contact your clinician. If you would like to file a complaint, you may contact:

- No Surprises Helpdesk (Federal Agency Contact)

Phone: 1-800-985-3059

Website: www.cms.gov/nosurprises

- Delaware Department of Insurance

Phone: (800) 282-8611

Email: consumer@delaware.gov

- Maryland Insurance Administration

Attn: Consumer Complaint Investigation Life and Health/Appeals and Grievance

Address: 200 St. Paul Place, Suite 2700 Baltimore, MD 21202

Telephone: 410-468-2000 or 800-492-6116 TTY: 1-800-735-2258

Fax: 410-468-2270 or 410-468-2260 (Life and Health/Appeals and Grievance)

Website: www.insurance.maryland.gov

Good Faith Estimate

Under the law, health care providers are required to give **patients who are Self-Pay** (don't have insurance or are not using insurance) an estimated bill for services. This estimated bill is called a "Good Faith Estimate."

If you are considered Self-Pay, your good faith estimate will include:

- A list of services your clinician expects to provide for a period of care (for a period of 12 calendar months)
- Costs associated with expected services
- Applicable diagnosis and service codes
- Notifications about your rights regarding the Good Faith Estimate
- information on how to dispute a bill if it is $400 or more than estimated

When will you receive your Good Faith estimate?

- At least 3 business days from the completion of your Free Consultation, if you communicate that you are interested in services
- For appointments scheduled at least 3 business days in advance; your GFE will be provided in 1 business day
- For appointments scheduled (or GFE requests made) at least 10 business days in advance; your GFE will be provided in 3 business days
- You will receive an updated GFE if there are any changes made in service fees or if expectations for services change
- You will receive an updated GFE annually with the completion of annual consents

How will i receive my Good Faith Estimate?

The GFE will be made available through your patient portal, email, and/or physical mail. You may communicate your preference in how you'd like to receive the GFE.

For questions or more information *about your right to a Good Faith Estimate or the dispute process, visit https://www.cms.gov/nosurprises/consumers or call 1-800-985-3059.*