MARYLAND
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ADMINISTRATION

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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.

2. How Can I Learn More about my Health Insurance Coverage?

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[1] 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.

3. 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 co-payment or coinsurance. You may not be billed for the balance by the provider.

[1] The term "insurance company" includes insurers, HMOs and non-profit health service plans.

4. 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.

5. 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 your insurance company, follow up by asking if the provider is "in-network" or "out-of-network."

6. 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.

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

You may have to pay more if you receive services from an out-of-network provider than if you receive the same services from an in-network provider.

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

8. 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.

9. 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.

10. 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. In some circumstances, you may be protected from balance billing. For example, if you are treated by a Maryland-licensed provider in an emergency room, the law may protect you. If you have a choice of providers, and you choose an out-of-network provider, you may have to pay the full amount of the provider's bill.

11. What is Custodial Care and is it Covered by Most Health Insurance Plans?

Custodial care can be provided in either a nursing home or at home, and includes daily activities such as bathing, dressing, and eating. These services can be provided by someone who does not have medical training. Custodial care is generally not covered by health insurance. Other options are available to pay for custodial care, including long-term care insurance. For more information about payment options, see the MIA's "Frequently Asked Questions on Long-term Care," talk with a trusted insurance producer, or visit www.longtermcare.gov.

12. 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.