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Frequently Asked Questions:

In-Network vs. Out-of-Network Providers

1. **Who or what is a health care provider?** A health care provider includes doctors, hospitals, and health care professionals who are licensed or authorized to provide health care services.
2. **What is an “In-Network” Provider?** These are providers that have a contract with your insurance company.¹ 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 “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.
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 copay or coinsurance may be larger than if the services had been provided by an in-network provider.

¹ The term “insurance company” includes insurers, HMOs and non-profit health service plans.

5. **What is “Balance Billing”?** 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.
6. **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 health plan. Make sure that you know the type of health benefit plan that you have. If you are told that a provider is “participating” or “accepts” payment directly from your health plan, follow up by asking if the provider is “in-network” or “out-of-network.”
7. **Can I see an “Out-of-Network” Provider?** It depends on the type of health benefit plan you have.
 - Some plans only allow you to see in-network providers unless it is an emergency, you do not have control over the provider you see such as when you receive in-patient services at a hospital, or you need a certain type of specialist and there is no specialist in the health plan’s network.
 - If you are covered under a health maintenance organization (HMO), you may be restricted from seeing an out-of-network provider.
 - Some 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 plan for this information.

8. **What will I have to pay if I see an “Out-of-Network” Provider?** 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).
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. 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 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.

11. 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].

12. 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.