Out-of-Pocket Maximum

This is the maximum amount that you pay before your insurance company will pay 100% of the allowable amount for covered health care services. Depending upon the terms of your policy or plan, this amount can include deductibles as well as copays and coinsurance. Check with your insurance company to determine what is included in this amount under your policy or plan.

Premium

The amount you and/or your employer pay to your insurance company for your policy or plan. This amount may be paid monthly, quarterly or yearly. Failure to pay the premium will result in cancellation of your policy or plan. For more information on how insurance companies determine premiums, see *Frequently Asked Questions: Health Insurance Rates and the Review Process* at *www.insurance.maryland.gov.*

Preventive Services

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 copayment 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 with 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 copay for the part of the visit dealing with the problem, even if the initial purpose of the visit was preventive.

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, please do not hesitate to contact the MIA at 800-492-6116 or visit our website at *www.insurance.maryland.gov*.

This consumer guide should be used for educational purposes only. It is not intended to provide legal advice or opinions regarding coverage under a specific policy or contract; nor should it be construed as an endorsement of any product, service, person, or organization mentioned in this guide.

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
www.insurance.maryland.gov

www.facebook.com/MdInsuranceAdmin
www.twitter.com/MD_Insurance
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(10/22)

A CONSUMER GUIDE TO

UNDERSTANDING YOUR HEALTH INSURANCE COSTS






Maryland
INSURANCE ADMINISTRATION

In order to fully understand the cost of your health insurance, it is important that you know the different costs for which you may be responsible and the terms used to describe them. Some of these key terms are defined below for general information purposes. You should check your policy or plan contract for specific information about how these terms are defined for purposes of your policy.

Allowable 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." You may have to pay the difference if your provider charges more than the allowable amount.

**The term "insurance company" includes HMOs and non-profit health service plans.*

Balance Billing

Balance billing happens when a health care provider (a doctor, for example) bills a patient after the patient's health insurance company has paid its share of the bill. The balance bill is for the difference between the provider's charge and the price the insurance company set, after the patient has paid any copays, coinsurance, or deductibles. Balance billing can happen when a patient receives covered health care services from an out-of-network provider or an out-of-network facility (a hospital, for example).

In some circumstances, when you go out-of-network, you may be protected from balance billing. Under the federal No Surprises Act, you cannot be balance billed if you:

1. Receive emergency services from an out-of-network provider or an out-of-network emergency facility.
2. Receive covered non-emergency services from an out-of-network provider while visiting an in-network health care facility, unless you willingly give written consent in advance to give up your protections. (You can never be asked to waive your protections for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, and intensivist services, and you will never be balanced billed for these services at an in-network facility).
3. Receive covered air ambulance services provided by an out-of-network provider of air ambulance services.

Additionally, 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.

Coinsurance

This is your share of the costs of a covered health care service. The coinsurance is applied after any deductible is satisfied. Your share is a percentage, such as 20%, of the allowable amount for the service. Here is how it works:

a. Your x-ray costs $200.
b. The insurance company has an allowable amount of $150.
c. Your coinsurance is 20%. Assuming your deductible has already been satisfied, you pay 20% of $150, which is $30 and the insurance company pays the remaining $120.

Copay

This is a set dollar amount that you must pay for a particular service. The amount may be different based on the type of service and whether the service is provided by an in-network or out-of-network provider. For example, your plan may require a $20 copay for an office visit to an in-network provider and a $40 copay for an office visit for an out-of-network provider. This fee may be in addition to any deductible for which you are responsible under the plan.

Deductible

This is the amount of money you must pay towards covered services before your insurance company will begin making payments. The deductible may not apply to all services that are covered by your policy or plan. Contact your insurance company for a list of services that are not subject to a deductible under your policy or plan. For a service subject to the deductible, you or your health care provider will submit a claim(s) to your insurance company even though you are responsible for paying the provider. The insurance company will then apply the allowable amounts for covered services to your deductible. When the total of the allowable amounts equals your deductible, the insurance company will begin to pay claims. Until you meet your deductible, you will need to pay the allowable amount to your health care provider. After you meet your deductible, you will pay only any applicable coinsurance or copay. Generally, you will have to meet your deductible every year.

In-Network Providers

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.

Out-of-Network Providers

An out-of-network provider does not have a contract with your insurance company. If you receive covered services from an out-of-network provider, the insurance company may not be required to pay any portion of the charges, or your copay or coinsurance may be higher 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 certain 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.