



Maryland

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Frequently Asked Questions: **In-Network vs. Out-of-Network** **Providers**

As of November 1, 2022

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 company¹. 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.

In some circumstances, you will not have to pay more for an out-of-network visit,

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

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.

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, 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:

- i. Receive emergency services from an out-of-network provider or an out-of-network emergency facility.
- ii. 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).
- iii. 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.

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?**

Sometimes, you may not be able to get the health care that you need from a specialist who is in your insurance company’s network. The in-network specialist may be unreasonably far away, or might not have an appointment for an unreasonably long time, or may not be able to treat your condition. When that happens, and you have to go to a specialist that is out-of-network, your insurance company may have to cover the out-of-network specialist the same as they would an in-network specialist. Your health insurance company has to have a process that you can use to find out how to get in-network coverage for care by an out-of-network specialist. And when you make your request, they have to respond quickly. You can contact your health plan using the number on the back of your card, or use the link: <https://bit.ly/miaccp> to find out the process to use for your insurance company.

IMPORTANT: *You must use the company process.* If you do not and you choose to see an out-of-network specialist, and in-network specialists were available, the services will be covered only if you have out-of-network benefits and only for the amount allowed for out-of-network coverage.

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 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).

However, beginning on January 1, 2023, if you are approved to see an out-of-network specialist for mental health or substance use disorder services, your health plan must pay the costs of the out-of-network specialist's services other than your cost-sharing amount (deductible, copay, coinsurance), which you must pay. Your health plan must ensure that the approved out-of-network services cost you no more than you would have paid if you received the services from a provider on the plan's provider panel. This means there will be no balance bill.

Also, under the federal No Surprises Act, your health plan may not balance bill you when:

- i. You receive covered emergency services from an out-of-network provider or an out-of-network emergency facility.
- ii. You receive covered non-emergency services from an out-of-network provider while visiting an in-network health care facility.
- iii. You receive covered air ambulance services provided by an out-of-network provider of air ambulance services.

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 about emergency situations when I just need the closest healthcare facility?

Sometimes you may not be able to choose a provider who is in your plan's network. You may need emergency treatment, or you may see an out-of-network provider at an in-network hospital. Under the federal No Surprises Act, health plans may not balance bill when:

- i. You receive covered emergency services from an out-of-network provider or an out-of-network emergency facility.
- ii. You receive covered non-emergency services from an out-of-network provider while visiting an in-network health care facility.
- iii. You receive covered air ambulance services provided by an out-of-network provider of air ambulance services.

12. 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].

13. 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.

Under the federal No Surprises Act, if you receive covered air ambulance services

provided by and out-of-network provider of air ambulance services, you cannot be balance billed.