NO SURPRISES ACT

The federal **No Surprises Act** became effective Jan. 1, 2022. The law aims to help patients understand health care costs in advance of care and to minimize unforeseen or surprise medical bills.

The Centers for Advanced ENT CARE has created this guideline to help you prepare and understand your health care costs. For your immediate reference, our website provides a list of plans that we are currently In Network with under the Insurances section.

Overview

- What is balance billing/ surprise billing?

Your plan may assign an out-of-pocket responsibility for when you see a doctor or other health care provider. Because of this, you may owe a copay, coinsurance and, or, a deductible. Your responsibility might increase when you visit a provider or facility that is outside your plan's network.
Balance Billing occurs when Out of Network providers bill you for the difference between "what your plan agreed to pay and the full billed amount. Surprise Billing is an unexpected balance bill.

- How are Patients Protected?

For certain scheduled care with out-of-network providers, patients must be given advance notice and give approval, where applicable, to be billed for any related out-of-network fee or amount.
Patients are protected from balance billing resulting from emergency services and for certain scheduled services at an in-network hospital or ambulatory surgery center.
Self-Pay Patients, patients without insurance or who do not wish to use their plan for coverage of services, have a right to receive a good faith estimate of their potential bill for medical services when scheduled at least three days in advance.
Individuals with Medicare, Medicare Advantage, Medicaid, Indian Health Services, VA health care, or TRICARE insurance plans are not covered under the No Surprises Act because these federal insurance programs have existing protections in place to minimize large, unforeseen bills.

- Why do we care?

The No Surprises Act will reduce instances where patients face unexpected medical bills due to receiving care from an out-of-network facility or provider during an emergency. Similarly, patients are protected from receiving surprise bills for certain scheduled services for which they could not reasonably know the network status of a provider.

Maryland Specific Balance Billing Protections

Patient enrolled in a health maintenance organization (HMO) governed by Maryland law, may not be balance billed for services covered by their plan, including ground ambulance services.

Patient enrolled in a preferred provider organization (PPO) or exclusive provider organization (EPO) governed by Maryland law, hospital-based or on-call physicians paid directly by the PPO or EPO (assignment of benefits) may not balance bill for services covered under the patient's plan, and they cannot ask them to waive their balance billing protections. If a patient uses ground ambulance services operated by a local government provider who accepts an assignment of benefits from a plan governed by Maryland law, the provider may not balance bill the patient.

Get a Cost of Care Estimate

You have the right to receive a good faith estimate ahead of scheduled nonemergency health care services, if you are an uninsured or self-pay patient. A good faith estimate shows the cost of items and services that are reasonably expected for your scheduled visit. The estimate is based on information known at the time the estimate was created, and can include costs related to your visit such as medical tests, medications, DME and facility fees.

Your provider's office will give you the estimate in writing at least one day before your medical service if your care has been scheduled at least three days in advance. You may also request an estimate at any time.

If you would like to receive a good faith estimate, please call your provider's billing department.

For details about the law, visit the No Surprises Act site from the Centers for Medicare and Medicaid Services.