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YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

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When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference betweenwhat your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care - like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Effective October 22, 2020, the Michigan legislature enacted Enrolled House Bill No. 4459, which established legislation regarding so-called "surprise billing" meant to limit the amount that can be charged to patients by out-of-network providers ("**Act**").

1. The Act applies to providers and facilities that do not have a contract with, and thus do not participate with, a health benefit plan.
2. A nonparticipating provider or facility treating a patient in a nonemergency situation is required to accept as payment in full the greater of: (a) the median amount negotiated by the patient's carrier for the region and provider specialty, excluding any in-network coinsurance, copayments, or deductibles, or (b) 150% of the Medicare fee-for-service fee schedule for the health care service provided, excluding any in-network coinsurance, copayments, or deductibles.
3. The fee limitation noted above applies if the health care service is provided to a nonemergency patient, is covered by the patient's health benefit plan, and is provided at a participating hospital facility and either: (a) the patient does not have the ability or opportunity to choose a participating provider, or (b) the nonemergency patient has not been provided the disclosure required under the

Act (discussed below).

4. The fee restriction noted above for nonemergency situations applies to health care services provided to an *emergency* patient if the service is covered by the patient's health benefit plan and is provided to the patient by the nonparticipating provider at a participating health facility or nonparticipating health facility.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you unless you give written consent and give up your protections.

You're never required to give up your protection from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact:

- Your Health Care Insurance Plan. The customer service number is on the back of your card.
- Visit the Department of Insurance and Financial Services website for more information about your rights under Michigan law or you can call them toll-free at 1-877-999-6442.

Visit https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf for more information about your rights under Federal law.

For more information, click the following link which reviews Michigan-specific information on your rights--
Michigan Surprise Billing Rights for Consumers