Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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 like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or a visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays the provider and the full amount charged by the provider. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're 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 they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in a stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Michigan law also protects you from balance billing and requires that you pay only your in-network cost sharing amounts for: (i) covered emergency services provided by an out-of-network provider at an in-network facility or out-of-network facility; (ii) covered nonemergency services provided by an out-of-network provider at an in-network facility if you do not have the ability or opportunity to choose an in-network provider; and (iii) any healthcare services you receive at an in-network facility from an out-of-network provider within 72 hours of receiving services from that facility's emergency room.

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 can 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 balanced billed. If you get other types of 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 protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

Additionally, Michigan law states if you consent to receive non-emergency care from an out-of-network provider, the balance billing prohibition does not apply. These protections apply to any patient covered by a Michigan health benefit plan and a self-funded plan established or maintained by the state or local unit of government for its employees.

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

- You're only responsible for paying your share of the cost (like copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to 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 (also known as "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 in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, contact your health insurance carrier. If your carrier is unable to resolve your billing inquiry, contact the Michigan Department of Insurance and Financial Services at 877-999-6442.

Visit https://www.michigan.gov/difs/-/media/Project/Websites/difs/Publication/Health/FIS-PUB_8540.pdf for more information about your rights under Michigan law.

The federal phone number for information and complaints is: 1-800-985-3059. Visit www.cms.gov/nosurprises/ for more information about your rights under federal law.