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Your Rights and Protections Against Surprise Medical Bills

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 between what 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.

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 protections 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.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

State of Michigan Comprehensive Balance Billing Protections

PROTECTIONS AVAILABLE

- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
    - To HMO and PPO enrollees
    - For (1) emergency services by out-of-network professionals and facilities; and (2) non-emergency services provided by out-of-network professionals at in-network facilities*
- Provided by all or most classes of out-of-network health care professionals
- State provides a payment standard**
- State provides a dispute resolution process***
- Protections do not apply to:
    - ground ambulance services
    - enrollees who consent to non-emergency out-of-network services****
    - enrollees in self-funded plans

Outside of the State Michigan

Check each state individually through their Department of Insurance. To find out if your state has any protections and to search by state, click to follow: State Balance-Billing Protections | Commonwealth Fund

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 bcbsm.com or contact the health plan by using the number on the back of your identification card.
Visit No Surprises Act | CMS (https://www.cms.gov/nosurprises) for more information about your rights under federal law.

Visit DIFS - Surprise Billing (michigan.gov)for more information about your rights under State of Michigan law.

Notes:

* With respect to non-emergency services provided by out-of-network providers at in-network facilities, protections are contingent on either a) enrollee not having the ability to choose a participating provider b) health care services provided without enrollee disclosure, or c) health care services provided by a non-participating provider at a participating facility to a enrollee admitted after receiving emergency services

** Payment standard is defined as the greater of 1) the median amount negotiated by the enrollee's carrier for the region and provider specialty (as determined by the enrollee's carrier) or 2) 150% of the Medicare fee-for-service fee schedule for the health care service provided. In both cases, in-network coinsurance, copayments, and deductibles are excluded.

***In cases where an enrollee has received emergency services, a non-participating provider can request an additional payment that is 25% of the payment standard amount if a complicating factor is identified. If the carrier rejects the request, a non-participating provider can initiate binding arbitration specific to whether there was a complicating factor.

**** Protections do not apply to non-emergency services when enrollee consents in writing. But when the enrollee does not have the ability to choose a participating provider or is admitted through the emergency room, protections do apply. To establish consent, documents need to be provided and signed by non-emergency enrollee at the earliest of the following:

1. At least 14 days before the scheduled procedure, or within 14 days if service will be provided within 14 days, for services not provided in physician's office or similar outenrollee setting

2. At the time of first contact with the non-emergency enrollee, for services provided in a physician's office or similar outenrollee setting.

3. During pre-surgical consultation, scheduling/intake call, pre-operative review, or any other similar event occurring before a service

4. Any other contact occurring before a health care service that is similar to the above.

Disclosure cannot be provided at the time of the non-emergency enrollee's admittance to a facility, or at the time of preparation for surgery or other medical procedure.