

McLaren Print System Order

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Your Rights and Protections Against Surprise Medical Billing

When you get emergency care or get treated by an out-of-network hospital or ambulatory surgical center, you are protected from surprise medical 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:

Spec Info: 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 balance billed for these post-stabilization services.

In addition to the protections of the Federal No Surprises Act, the state in which you receive services may have protections that apply to your visit for emergency or non-emergency services. Michigan and Ohio limit the amount an out-of-network provider and facility can bill you for emergency

When balance billing is prohibited and what protections:

- You are only responsible for copayments, coinsurance, and deductibles if the provider or facility was an in-network provider and facility.
- Your health plan generally must:
 - Cover emergency services in advance (pre-authorization).
 - Cover emergency services if you don't have pre-authorization.
 - Base what you owe the provider on what you would pay an in-network provider for the same service, with your explanation of benefits (EOB) as evidence.
 - Count any amount you pay for emergency services toward your out-of-pocket limit.

If you believe you've been balance billed, contact your plan's Corporate Compliance hotline or the Centers for Medicare and Medicaid Services.

Visit www.cms.gov/nosurprises for more information under federal law. Visit <http://www.michigan.gov/insurance.ohio.gov> for your state's rules.

You have the right to receive advance notice of how much your health care services will cost.

Under the law, health care providers and facilities must give you advance notice of health care services and their costs before you receive them, unless it's an emergency.