McLaren Business Products

McLaren Print System Order

Order No: 91799
Order Date: 2025-01-22
User: Tim Nemecek
Phone: (810) 342-1228

Ship Location: KCI Flint - TIM NEMECEK
4100 Beecher Rd
Flint, MI 48532
Brochures
Quantity: 1
Paragon Dept No: 43011
Dept Name: Radiation Oncology
Company Number: 60

Order Total Price: 5.50

Item Number: MHCC-2804-1824
Item Description: Rights and Protections Poster
Revision Date: 10/2024
Print:
Paper:
Size:
Fold:
Finish:
Drill:
Poster: 11x17 paper
Misc Info:

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 agrees 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 those 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 cost for emergency or non-emergency services. Michigan and Ohio limit the amount an out-of-network provider and facility can bill you for emergency services. Additional information is available from your state government. Michigan residents can visit https://www.michigan.gov/difs/0,5269,7-303-12902_82812_82813_82814_107600-497218--,00.html. Ohio residents can visit https://insurance.ohio.gov/consumers/health-insurance/billing.

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, and intensivist providers. 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 those 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.

In addition to the protections of the Federal No Surprises Act, the state in which you receive services may have protections that apply to non-emergency services at an in-network facility. Additional information is available on your state's website. Michigan residents can visit https://www.michigan.gov/difs/0,5269,7-303-12902_82812_82813_82814_107600-497218--,00.html. Ohio residents can visit https://insurance.ohio.gov/consumers/health-surprise-billing.

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 the McLaren Corporate Compliance hotline at 1-866-MHC-Comply (1-866-642-4675), or the Centers for Medicare and Medicaid Services at 1-800-985-3059.

Visit www.cms.gov/nosurprises for more information about your rights under federal law. Visit https://www.michigan.gov/DIFS/consumers for more information about your rights under Michigan law, or visit www.insurance.ohio.gov for your rights under Ohio law.

YOU HAVE THE RIGHT TO RECEIVE A "GOOD FAITH ESTIMATE" EXPLAINING HOW MUCH YOUR HEALTH CARE WILL COST.

Under the law, health care providers need to give patients who don't have certain types of health care coverage (or who are not using certain types of health care coverage) an estimate of how much they will charge for certain items and services before those items or services are provided.

- You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- If you schedule a health care item or service at least 3 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask any health care provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after you ask.
- If you receive a bill that is at least $400 more than your provider or facility's Good Faith Estimate from that provider or facility, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate and the bill.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

McLaren HEALTH CARE

Spec Info: