Patient Protection Disclosure

When applicable, it is important that individuals enrolled in a plan or health insurance coverage know of their rights to: (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization. Accordingly, the interim final regulations regarding patient protections under section 2719A of the Affordable Care Act require plans and issuers to provide notice to participants of these rights when applicable. The notice must be provided whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage. This notice must be provided no later than the first day of the first plan year beginning on or after September 23, 2010.

The following model language can be used to satisfy the notice requirement:

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

> Blue Care Network generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, Blue Care Network designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Blue Care Network at 800-662-6667, or https://www.bcbsm.com/individuals/find-care/.

For plans and issuers that require or allow for the designation of a primary care provider for a child, add:

> For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

You do not need prior authorization from Blue Care Network or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [Blue Care Network at 800-662-6667, or https://www.bcbsm.com/individuals/find-care/.

Summary of Benefits and Coverage (SBC)

As part of the federal Affordable Care Act, health carriers and group health plans are now required to provide current and prospective members with a Summary of Benefits and Coverage (SBC). The SBC must include Coverage Examples which are intended to show how the plan might cover medical care in a given situation. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans. It is important to note that the SBC is not a contract.

For a complete description of benefits and terms of coverage, consult the applicable Blue Cross Blue Shield of Michigan and Blue Care Network plan documents. A stand-alone, standard glossary of medical and insurance terms must also be provided. Please note these are federal agency definitions and do not necessarily reflect Blue Cross Blue Shield of Michigan and Blue Care Network definitions of the same terms. You may obtain a copy of the SBC and Uniform Glossary Document from the Blue Cross Blue Shield of Michigan and Blue Care Network or at https://www.waynecountymi.gov/Government/Departments/PersonnelHuman-Resources/Benefits/Health-Benefit-Summaries-Details.

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.

[***Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language regarding applicable state law requirements as appropriate***]

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 DIFS (Department of Insurance and Financial Services). DIFS can help you with health insurance questions and complaints and can provide general information about Michigan's surprise medical billing law. Contact DIFS Monday through Friday from 8 a.m. to 5 p.m. at 877-999-6442 or visit the DIFS website to file a complaint at Michigan.gov/DIFScomplaints. You may make complaints against medical providers by contacting the Michigan Department of Licensing and Regulatory Affairs (LARA), Bureau of Professional Licensing. You can find information about LARA's complaint process on its website at Michigan.gov/LARA/Bureau-List/BPL/Complaint. Visit https://www.cms.gov/medical-bill-rights for more information about your rights under federal law.