COUNTY OF ST. CLAIR

November 1, 2022

Federal Regulation Required Employer Notices

Tell Us When You're Medicare Eligible
Please notify Human Resources when you or your dependents become eligible for Medicare. You will need to provide Human Resources with a copy of your Medicare card. We are required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the health plan pays primary. You must also contact Medicare directly to notify them that you have health care coverage through an employer group. Privacy laws prohibit anyone other than the Medicare beneficiary, or their legal guardian, to update or change Medicare records. The toll free number to contact Medicare Coordination of Benefits Contractor is 1-800-999-1118.

Special Enrollment Notice
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Stephanie Frizzle in Human Resources at 810/989-6910.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires employer health plans to maintain the privacy of your health information and to provide you with a notice of the Plan's legal duties and privacy practices with respect to your health information.

Michelle's Law
Michelle's Law is an act that requires health plans to allow college students who take a leave of absence or reduce their class load because of illness to retain their dependent status under their parents' health plan for up to one year. Students' eligibility for dependent coverage will continue for one year (unless the student would otherwise lose eligibility within the year). To qualify for protection under Michelle's Law, the following requirements must be met: the student must be enrolled as a fulltime student immediately before the leave of absence or scheduled reduction, the student must have written certification from a treating physician that the leave of absence or reduced schedule is necessary due to a severe illness or injury, and the leave or reduced schedule must have triggered the loss of student status under the health plan. If the plan sponsor changes group health plans during a medically necessary leave and the new health plan offers coverage of dependent children, the new plan will be subject to the same rules.

Newborns' Act Disclosure Notice
Group Health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998
"Janet's Law" requires health care benefit plans to provide certain coverage following a mastectomy. As part of this coverage, plans must also cover procedures necessary to effect reconstruction of the breast on which the mastectomy and surgery to achieve a symmetrical appearance, as well as the cost of prostheses (implants, special bras, etc.) Coverage is also provided for physical complications of all stages of mastectomy, including lymphedemas, as recommended by the attending physician of any patient receiving plan benefits in connection with the mastectomy. This coverage is subject to the same deductibles and co-insurance that apply to mastectomies under current terms.

Genetic Information Nondiscrimination Act of 2008 (GINA)
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic Information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Nondiscrimination Notice
Our goal is to treat you fairly. That's why we follow federal civil rights laws in our health programs and activities. We do not view or treat people differently because of their race, color, national origin, sex, age or disability. If you need help with any of the information we provide you, please let us know. We offer services that may help you. These services include aids for people with disabilities, language assistance through interpreters and information written in other languages. These are free at no charge to you. If you need any of these services, please call us at the number on the back of your member ID card. If you feel at any time that we didn't offer these services or we discriminated based on race, color, national origin, sex, age or disability, please let us know. You have the right to file a grievance, also known as a complaint. If you need help filing a complaint, please contact Blue Cross Blue Shield, Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, or by telephone at (888) 605-6461, TTY: 711, or by fax at (866) 559-0578, or by email at CivilRights@bcbsm.com.

You can also contact the U.S. Department of Health and Human Services, Office for Civil Rights at:
U.S. Department of Health and Human Services, Office for Civil Rights
200 Independence Avenue SW, Room 509F, HHH Building
Washington, DC 20201

Phone: 1.800.368.1019 or 1.800.537.7697 (TDD)
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Email: OCRComplaint@hhs.gov
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Important Notice from St. Clair County About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with St. Clair County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. St. Clair County has determined that the prescription drug coverage offered by the St. Clair County Employee/Retiree Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you do decide to enroll in a Medicare drug plan, your current **St. Clair County** coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current **St. Clair County** coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact your Plan Administrator for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with **St. Clair County** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about Your Current Prescription Drug Coverage…

Contact your Benefits Administrator for **St. Clair County** at (810) 989-6910. For a further explanation of the prescription drug coverage plan provisions/options under the **St. Clair County Employee/Retiree Health Plan** please consult the relevant plan document provisions.

For More Information about This Notice…

Contact your Benefits Administrator for **St. Clair County** at (810) 989-6910.

NOTE: You will receive this notice each year. You will also get it before the next period you can enroll in a Medicare prescription drug coverage, and if this coverage through St. Clair County changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	**October 15, 2022**
Name of Entity/Sender:	**St. Clair County**
Contact--Position/Office:	**Tina Delia, Human Resources**
Address:	**200 Grand River Ave, Suite 206, Port Huron, MI 48060**
Phone Number:	**(810) 989-6910**

COUNTY OF ST. CLAIR

November 1, 2022

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877- KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

Continued on Next Page

If you live in one of the following states, you may be eligible for assistance paying your employer healthplan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

KANSAS – Medicaid	MONTANA – Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP	**SOUTH DAKOTA - Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

OKLAHOMA – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 6156

NOTICE REQUIRED BY STATE OF MICHIGAN

* FOR INFORMATION ONLY *

NONOPIOID DIRECTIVE

Michigan Department of Health and Human Services

Required by MCL 333.9145 effective 3/28/2019

MUST BE INCLUDED IN THE PATIENT'S MEDICAL RECORD

Patient Name	Date of Birth
Other names used by patient	Preferred language of patient
Emergency Contact	Name of primary care provider
Drug allergies	

The patient above must not be administered an opioid or offered a prescription for an opioid while this directive is in effect.

- An individual who has executed a nonopioid directive on their own behalf may revoke the directive at any time and in any way they are able to communicate their intent to revoke the form.
- A guardian or patient's advocate can revoke at any time by issuing a revocation in writing and providing notice of the revocation to the individual's health professional or their delegate.
- This directive does not apply to:
  - A patient receiving opioids for substance use disorder treatment;
  - A patient who is in hospice;
  - A patient is being treated at a hospital, or in a setting outside of a hospital in the case of an emergency, and, in the prescriber's professional opinion, the administration of the opioid is medically necessary to treat the individual.

Signature of patient, or if the patient is a minor, parent	Date
Printed name of Patient	Date
Signature of guardian or patient's advocate, if applicable	Date
Printed name of parent/guardian/patient's advocate, if applicable	Date

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

DOL Surprise Billing Notice
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.

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.