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Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are 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. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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, like a copayment, coinsurance, or deductible. You may have additional 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" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays 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 plan's deductible or 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider, facility, the most they can bill you is the plan's in-network cost-sharing amount (such as copayments, coinsurance and deductibles). You **can't** be balance billed for these emergency services. This includes services you may receive 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 receive 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 can bill you is the 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 types of services at an in-network facility, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in the plan's network.

When balance billing isn't allowed, you also have these protections:

- You're responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). The plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, the plan will:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) for these services on what the plan 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 these out-of-network services toward your in-network deductible and out-of-pocket limit.

FOR MEMBERS: **If you believe you've been wrongly billed**, you may contact the Department of Health and Human Services (HHS) via its toll-free number at 1-800-985-3059.

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

FOR PROVIDERS: The Federal No Surprises Act (NSA) applies for this claim. We allowed covered services using the recognized Qualifying Payment Amount (QPA). The QPA complies with the NSA. We calculated the member's cost share using the QPA. The member only owes their cost share shown on this notice. You are prohibited from billing the member more than their cost share. Under NSA, if you don't accept the QPA and want to initiate an Open Negotiation, you have 30 business days from receipt of this notice to do so. You can submit a completed Open Negotiation request form to us via email at claiminquiry@clearhs.com, via our online portal (preferred method), https://provider.clearhs.com or by calling Clear Health at 1-866-722-3773 if you need details on initiating an Open Negotiation. If we don't reach an agreement during the Open Negotiation, you may initiate the Federal Independent Dispute Resolution (IDR) process for eligible claims on business day 31.