Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by a Non-Direct provider at an CLIENT Direct hospital or ambulatory surgery center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a Non-Direct 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 if you see a provider or visit a health care facility that isn't CLIENT Direct.

"Non-Direct" describes providers and facilities that haven't signed a contract with the CLIENT (the "Plan"). Non-Direct providers may be permitted to bill you for the difference between what the Plan agreed to pay, and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than CLIENT Direct 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, for example, when you have an emergency or when you schedule a visit at an CLIENT Direct facility but are unexpectedly treated by a Non-Direct provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from a Non-Direct provider or facility, the most the Non-Direct provider or facility may bill you is the Plan's CLIENT Direct 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 a CLIENT Direct hospital or ambulatory surgery center
When you get services from a CLIENT Direct hospital or ambulatory surgery center, certain providers there may be Non-Direct. In these cases, the most those Non-Direct providers may bill you is the Plan's CLIENT Direct cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These Non-Direct 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 CLIENT Direct facilities, Non-Direct 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 from Non-Direct providers or facilities. You can choose a provider or facility that is CLIENT Direct.

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 CLIENT Direct). The Plan will pay Non-Direct providers and facilities directly.

- The Plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by Non-Direct providers.

    - Base what you owe the Non-Direct provider or facility (cost-sharing) on what it would pay an CLIENT Direct provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or Non-Direct described in this Notice toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the U.S. Department of Health & Human Services at 1-800-985-3059.

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