



Out-of-Network Liability and Balance Billing

If you receive Covered Services from a Non-Plan Provider, your cost-sharing will be higher, as described in the Out-of-Network portion of your Schedule of Benefits. It is your responsibility to ensure the Providers you receive services from are in the Health Options Network. If Community Health Options (“Health Options”) approves your claim for payment of services rendered by a Non-Plan Provider, we will pay Benefits up to the Maximum allowable amount. We will pay Benefits directly to you or to the Non-Plan Provider.

Charges above the Maximum allowable amount will not apply to your Out-of-Network cost-sharing and will be your responsibility, if the Non-Plan Provider chooses to bill you. This means you may have financial responsibility greater than the cost-sharing described on your Schedule of Benefits. This is sometimes referred to as Balance Billing. Before you receive a service, you may call Health Options toll-free at 1-855-624-6463 (TTY/TDD: 711) to learn the network status of the Provider. If we deny your claim, you have the right to appeal our decision by following the steps in your Member Benefit Agreement. For Medical Emergency services rendered by a Non-Plan Provider, we will provide Benefits at Plan Provider Out-of-Pocket Costs based on the Maximum allowable amount, as determined by us, for the services received.

If you need Medical Emergency services, you should go immediately to the nearest emergency department or call 9-1-1 or another local emergency number. You do not need Prior Approval for Medical Emergency services. Medical Emergencies include, but are not limited to:

- Heart attack;
- Stroke;
- Severe trauma;
- Shock;
- Loss of consciousness;
- Seizures; and
- Convulsions.

Once your emergency medical condition is stabilized, Notification and Prior Approval requirements apply for all services that require Notification or Prior Approval.

If you are hospitalized, Notification to Health Options via our Member Services toll free number at 1-855-624-6463 is required within 48 hours of the admission. When you are admitted to a Plan Provider facility, the staff at that facility is required to notify Health Options of your admission. If you are admitted to a Non-Plan Provider facility, you or your Designee is required to notify your PCP and Health Options within 48 hours of admission. Your PCP will arrange for any follow-up care you may need.

Your emergency department Out-of-Pocket Costs are listed on the Schedule of Benefits. If you are admitted to the Hospital from the emergency department, your Out-of-Pocket Costs for the emergency department visit as outlined in the Schedule of Benefits will be waived.

Should you seek Medical Emergency services at a Hospital that is a Non-Plan Provider, your Out-of-Pocket Costs for the Maximum allowable amount, as determined by Health Options, will be at the Plan Provider (or In-Network) cost-sharing level. You may be responsible for charges above the Maximum allowable amount.