SYNOPSIS OF THE IMPLEMENTATION OF P.L. 2018, C. 32 (N.J.S.A 26:2SS-1 TO -20), OUT-OF-NETWORK CONSUMER PROTECTION, TRANSPARENCY, COST CONTAINMENT AND ACCOUNTABILITY ACT

On June 1, 2018, the Out-Of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act, P.L. 2018, c. 32 (N.J.S.A. 26:2SS-1 to -20, "the Act"), was enacted, and will become effective on August 30, 2018. This Act enhances consumer protections from surprise bills for inadvertent and emergency or urgent ("inadvertent and involuntary") out-of-network health services, in addition to making changes to several elements of New Jersey's health care delivery system. These improvements include transparency and consumer disclosure requirements, the creation of an arbitration system, and cost containment for inadvertent and involuntary out-of-network services. The Department of Banking and Insurance ("Department") intends to propose regulations to implement the Act in the near future. Due to the short time until the effective date of the Act, the Department intends to issue a Bulletin to provide guidance to carriers, which as defined in the Act includes health carriers issuing health benefits plans, multiple employer welfare arrangements ("MEWAs") and the State Health Benefits Program and the School Employees' Health Benefits Program and other entities providing health benefits plans; health care providers; and other interested parties to assist them in meeting their obligations under the Act pending the adoption of rules. Accordingly, the Department is providing this advance notice and is seeking your feedback concerning the implementation of the Act as described herein.

CLAIMS PROCESSING AND ARBITRATION

Processing of Claims for Inadvertent and Involuntary Out-of-Network Treatment Prior to Arbitration, N.J.S.A. 26:2SS-9

Consistent with the guidance below, carriers must comply with the provisions of the prompt payment laws in processing claims for inadvertent and involuntary out-of-network treatment.

1) Initial Out-of-Network Claims Processing:

Pursuant to N.J.S.A. 26:2SS-9(c), upon the receipt of a claim for inadvertent or involuntary out-of-network treatment, carriers must either:

Option 1

Pay the charges as billed by the out-of-network health care provider; or,

Option 2

Determine within 20 days of the receipt of the claim that the out-of-network healthcare provider's billed charges are excessive and process the claim as follows:

- Remit payment for its portion of the allowed charge to the out-of-network health care provider with remittance advice detailing:
    - that the claim is for inadvertent and/or involuntary out-of-network treatment, that the carrier has determined that the billed charges are excessive, and the methods to initiate negotiation, and which must include certified mail, email, and online form submission;
    - that the carrier is not paying the out-of-network health care provider's billed charges, and instead, is paying its portion of what has been initially determined to be the allowed charge;
    - that if the out-of-network health care provider does not accept the carrier's payment of the initial allowed charge as payment in full, the out-of-network health care provider has the right to negotiate with the carrier for 30 days from the date of the carrier's initial payment of its portion of the allowed charge; and
    - that to exercise this right, the out-of-network health care provider must advise the carrier of its intent to reject the carrier's payment of its portion of the initial allowed charge as payment in full by either certified mail, email, or online submission within seven business days of the receipt of the carrier's portion of the allowed charge.

- Upon the issuance of the payment for its portion of the initial allowed charge to the out-of-network health care provider, the carrier must issue an Explanation of Benefits ("EOB") to the covered person that includes text, or is accompanied by a separate document, which details that:
    - the out-of-network claim is for inadvertent and/or involuntary out-of-network benefits and the carrier has determined the charges are excessive;

- the carrier is not paying the out-of-network health care provider's billed charges and is paying its portion of what has been initially determined to be the allowed charge;
- the out-of-network provider can reject the amount paid by the carrier as being considered payment in full;
- if the amount paid by the carrier for its portion of the initial allowed charge is rejected by the out-of-network health care provider, the amount of the allowed charge may be subject to further negotiation;
- if negotiation is pursued and is successful, the amount of the allowed charge may increase, which will result in the carrier paying more and may increase the covered person's cost-sharing for the out-of-network claim; and
- if negotiation is unsuccessful, both the carrier and the out-of-network health care provider can seek to enter into arbitration.

2) Negotiation:

If the out-of-network health provider opts to negotiate, the carrier and the out-of-network health care provider may engage in negotiations for no more than 30 days following the date of the carrier's initial payment of its portion of the allowed charge. As provided in the remittance advice, set forth above, the out-of-network health care provider seeking to engage in negotiation must advise the carrier of its intent to reject the carrier's payment of its portion of the initial allowed charge as payment in full within seven business days of receipt of the carrier's portion of the allowed charge. See N.J.S.A. 26:2SS-9.

When Settlement is Achieved: If a negotiated settlement is reached as to the allowed charge within 30 days, the carrier must remit payment for its portion of the outstanding amount of the negotiated allowed charge to the out-of-network health care provider within 30 days of settlement. This payment must be accompanied by remittance advice to the out-of-network health care provider, and a Final EOB to the member, which may be accompanied by a separate writing if needed, that sets forth:

- that the final allowed charge has been successfully negotiated between the carrier and the out-of-network health care provider, and that this negotiated amount will be accepted as payment in full for the out-of-network claim;
- the amounts of the initial allowed charge, initial carrier payment, and the covered person's cost-sharing based on those amounts;
- the amounts of the negotiated allowed charge, revised carrier payment, and the covered person's final cost-sharing for the claim as of the time of reprocessing; and

- the amount paid by the carrier, based on the difference between the initial payment and its responsibility for the negotiated allowed charge.

When Settlement is Not Achieved: If a negotiated settlement is not reached, the carrier, within seven days of the expiration of the 30-day negotiation period, must:

- Issue a Pre-Arbitration EOB, which may be accompanied by a separate document if needed, to the covered person, and the Pre-Arbitration EOB, remittance advice, or a similar notice, to the out-of-network health care provider, that sets forth the following:
    - That a negotiated settlement of the allowed charge was not achieved;
    - The amounts of the initial allowed charge, initial carrier payment, and the covered person's cost-sharing based on those amounts;
    - The amounts of the final offer allowed charge, revised carrier payment, and the covered person's final cost-sharing for the claim as of the time of reprocessing;
    - That if the carrier's final offer allowed charge is higher than the initial allowed charge, then the carrier must advise that the amount of the carrier's allowed charge has increased and that the covered person's total cost-sharing has or has not increased, depending on the circumstances of the covered person's cost-sharing at the time of reprocessing;
    - The additional amount paid by the carrier with the Pre-Arbitration EOB calculated as the difference between its initial payment and its portion of the final offer allowed charge; and
    - That the covered person's cost-sharing will not increase further, even if the carrier or out-of-network health care provider enter into binding arbitration; and

- Remit additional payment of its portion of the final offer allowed charge to the out-of-network health care provider.

Arbitration of Claims for Inadvertent and Involuntary Out-of-Network Treatment

This arbitration process applies to all out-of-network claims for services provided in New Jersey by a provider that is licensed or certified in New Jersey with dates of service on and after August 30, 2018, under health benefits plans issued in New Jersey, and to self-funded health benefits plans covering New Jersey residents that opt-in under the Act. N.J.S.A. 26:2SS-10 and 11. For inadvertent and involuntary out-of-network claims with multiple dates of service submitted on one claim, e.g. hospitalization beginning on August 29, 2018 and ending on September 1, 2018, the arbitration process under the Act only applies if the initial date of service is on or after August 30, 2018. In this example, the hospitalization is not eligible for arbitration

because the initial date, August 29, 2018, occurred prior to the effective date of the Act. This arbitration process does not apply to voluntary out-of-network treatment or out-of-network treatment provided through an in-plan exception. Additionally, the following claims handling processes and disclosures must be implemented by all carriers for handling of all inadvertent and involuntary out-of-network claims for services rendered on or after August 30, 2018.

For inadvertent and involuntary out-of-network claims that are not resolved as paid-in-full pursuant to the claims and negotiation processes as set forth above, the carrier, out-of-network health care provider, or covered person can request to enter binding arbitration within 30 days of the date of payment of the carrier's final offer if:

- the difference between the carrier's final offer allowed charge and the final offer of the out-of-network health care provider is $1,000 or higher;
- all applicable preauthorization or notice requirements of the health benefits plan were complied with; and
- the matter does not involve:
    - a dispute as to whether a treatment or service is medically necessary;
    - a treatment or service that is experimental or investigational;
    - a treatment or service that is cosmetic; or
    - a treatment or service that is medical or dental for which the carrier should have authorized services to be performed by an out-of-network provider through an in-plan exception because the carrier's network lacks a provider who is accessible and possesses the requisite skill and expertise to perform the needed services.

From August 30, 2018, through August 30, 2019, the Department will use its current vendor for Independent Claims Payment Arbitration system to administer the Out-of-Network Arbitration Program ("OON Arbitration"), MAXIMUS, Inc. ("MAXIMUS"). Thereafter, the Department will engage the services of an arbitration vendor for OON Arbitrations through its procurement processes. See N.J.S.A. 26:2SS-10(b)(3).

During the initial year, instructions as to how to file OON Arbitration requests will be posted on MAXIMUS's website. OON Arbitration shall be initiated by submitting a completed OON Arbitration Request Application directly to MAXIMUS through its website.

Upon receipt of a request for arbitration, MAXIMUS will promptly review the request to determine whether it is eligible for arbitration pursuant to the requirements of the Act, as set forth herein, and for completeness. MAXIMUS shall accept for processing a complete application that meets the following criteria:

- The covered person's health benefits plan was delivered, or issued for delivery, in New Jersey and is not an out-of-state plan or a Federal plan, including Managed Medicaid;
- The disputed amount is $1,000 or more;
- An out-of-network health care provider who is licensed in New Jersey rendered a covered service to a covered person under the health benefits plan on an inadvertent or involuntary basis in New Jersey;
- The covered person was enrolled in the health benefits plan at the time the service was rendered;
- The party's final offer for the allowed charge is specified in the request, which for a requesting carrier shall be the amount in the Pre-Arbitration EOB;
- The application includes, or the covered person has previously submitted, a fully-executed Consent to Release of Medical Records for Claim Payment and Arbitration form in the event the covered person's confidential information accompanies the arbitration request; and
- The party initiating the arbitration request has submitted all information requested by MAXIMUS as necessary to the OON Arbitration Request Application, with the applicable fee.

MAXIMUS shall reject an OON Arbitration Request Application received in excess of 30 days after the carrier's payment of its portion of the Final Offer Allowed Charge.

Within seven business days of the receipt of an OON Arbitration Request Application, MAXIMUS shall acknowledge receipt of the application to the parties and provide notice of any deficiencies in the application or accompanying documents, and of the procedures for correcting the deficiencies. If the initiating party fails to correct any deficiencies within 15 days, the OON Arbitration Request Application will be deemed withdrawn. If the responding party fails to correct

any deficiencies within 15 days and the initiating party has complied with all requests, the award may be issued for the initiating party upon notice to all parties and a continuing failure to cure the deficiencies within the time frames provided in that notice.

If an OON Arbitration Request Application is rejected based on information submitted with the OON Arbitration Request Application, MAXIMUS shall retain the initiating party's review fee and refund the arbitration fee. If the OON Arbitration Request Application is initially accepted, but later rejected as ineligible based on information submitted in whole or in part by the non-initiating party, MAXIMUS shall retain the review fees of both parties and refund the arbitration fees.

The only evidence admissible in the arbitration proceeding, or on which the arbitrator's determination may be made, are the documents submitted to, requested by, and accepted by MAXIMUS from the parties to the dispute. In-person or telephonic testimony will not be permitted. Within 30 days of the receipt of a complete OON Arbitration Request Application and accompanying documents, the arbitrator will issue a decision, which is subject to the following requirements:

- The decision must be in writing and issued by an arbitrator certified by the American Arbitration Association;
- The decision must select either the final offer of the out-of-network health care provider or of the carrier as the amount awarded;
- The decision will split the costs of the arbitration between the parties to the arbitration unless the carrier is found to not have acted in good faith;
- The decision will not award legal fees or costs; and
- The decision will be binding on all parties, and will only be subject to vacation or modification in accordance with N.J.S.A. 2A:24-1.

If the health care provider prevails in the arbitration, the carrier must remit payment of the difference between its portion of its final offer allowed charge and the arbitration award within 20 days of the date of the arbitration decision. The carrier must pay the arbitration award in full

without any increase in cost-sharing for the covered person. If the carrier fails to remit payment within this timeframe, interest of 12 percent per annum will accrue, starting on the 21st day after the date of the arbitrator's decision, pursuant to Health Claims Authorization, Processing and Payment Act ("HCAPPA"), P.L. 2005, c. 352. Interest will terminate on the date of payment, but no later than 150 days after the date of the claim receipt, unless the parties agree to a longer period of time.

Carriers must notify the covered person, if not a party to the arbitration, of the results of the arbitration award upon payment of an arbitration award, but no later than 30 days from the date of the decision. Carriers must notify the covered person of the arbitration result through the issuance of a Final EOB (with any necessary separate documentation) that advises of the following:

- The arbitration decision has been issued;
- The amount of the arbitration award for final allowed charges, any revised carrier payment based on the arbitrator's award, and the covered person's final cost-sharing for the claim as of the time of reprocessing, which shall not be greater than the covered person's cost-sharing based on the carrier's final offer allowed charge as disclosed in the Pre-Arbitration EOB;
- The amount, if any, paid by the carrier based on the difference between the final offer allowed charge and the arbitration award; and
- That this notice is provided only for the information of the covered person, and that the covered person is not responsible for any increased cost-sharing as a result of the arbitration award.

Process for Arbitration without Opt-In by Self-Funded Health Benefits Plans

For any self-funded health benefits plan issued in New Jersey that does not opt to participate in the OON Arbitration system, the plan member or the out-of-network provider may request binding arbitration for inadvertent and involuntary out-of-network claims if there is no resolution of a payment dispute within 30 days after the plan member is sent a bill for the services. Voluntary out-of-network claims are not eligible for arbitration. An out-of-network health care

provider must not collect or attempt to collect reimbursement from the plan member, including initiation of collection proceedings, until a request for arbitration is filed. Arbitrations under this section will be administered by the Department's OON Arbitration vendor, as discussed above.

OON Arbitration must be requested by submitting a completed OON Arbitration Request Application directly to MAXIMUS. Upon receipt of a request, MAXIMUS will promptly review the request to determine whether it is eligible for arbitration pursuant to the requirements of the Act and set forth herein and the completeness of the application. MAXIMUS will accept for processing a complete application that meets the following criteria:

- The health benefits plan at issue is a self-funded plan that has not opted to participate in OON Arbitration pursuant to the Act;
- The self-funded plan covers inadvertent and involuntary out-of-network services;
- The member was enrolled in the self-funded plan at the time the service was rendered;
- The member has been balance billed by an out-of-network health care provider;
- The application includes, or the covered person has previously submitted, a fully-executed Consent to Release of Medical Records for Claim Payment and Arbitration form in the event the plan member's confidential information accompanies the arbitration request; and
- The initiating party has submitted to MAXIMUS all information requested by the arbitration organization as necessary to the OON Arbitration Request Application.

MAXIMUS will not accept the request unless 30 days have elapsed from issuance of the health care provider's bill to the plan member. The arbitration proceeding will be conducted pursuant to the procedures set forth above.

Within 30 days of receipt of a complete OON Arbitration Request Application and accompanying documents, the arbitrator will issue a decision subject to the following requirements:

- The decision must be in writing and signed by the arbitrator who must be certified by the American Arbitration Association;
- The only evidence admissible in an arbitration proceeding, or on which the arbitrator's determination may be made, are the documents submitted to, requested by, and accepted by MAXIMUS by the parties to the dispute. In-person or telephonic testimony will not be permitted;

- The decision must award an amount that the arbitrator determines is reasonable for the service;
- This amount will be binding on the plan member and the health care provider, and must include a non-binding recommendation to the entity providing or administering the self-funded health benefits plan of an amount that would be reasonable to contribute to payment for the service; and
- The decision will split the costs of the arbitration between the parties to the arbitration unless the payment would pose a financial hardship to the plan member, which can be demonstrated by total family income below 250% of the Federal Poverty Level. Each party will be responsible for their own costs and fees, including legal fees.

Self-Funded Health Benefits Plans and Out-of-Network Arbitration

All carriers, third party administrators, or other entities that provide or administer a self-funded health benefits plan in this State should issue a health plan identification card to the primary covered person under a self-funded health benefits plan. The carrier, third party administrator, or other entity may contract with an administrator, agent, contractor or other vendor to issue the cards; however, the entity licensed in this State responsible for administration of the self-funded plan remains responsible for the proper issuance of the cards and for their compliance. Issuance of compliant identification cards must occur upon the earliest of the following: issuance of a new or renewal plan, or the self-funded plan's opt-in to OON Arbitration.

The following information should appear on the identification cards in a readily identifiable manner:

- The name of the carrier, third party administrator, or other entity administering the self-funded health benefits plan;
- Upper-case text as follows on the front of the card: "SELF-FUNDED";
- Text indicating whether the self-funded health benefits plan is participating in arbitration pursuant to N.J.S.A. 26:2SS-9, which is to be located on the front of the card below or adjacent to "SELF-FUNDED." Additionally, the card should indicate if the plan has elected to participate in arbitration: "NJ Arbitration – Yes, as of [insert effective date (date after which all inadvertent and involuntary OON claims incurred are subject to arbitration) that is at least two weeks after providing the card]"; or if the plan has declined to participate in arbitration: "NJ Arbitration – No."

Additionally, every entity that provides or administers a self-funded health benefits plan that elects to be subject to out-of-network arbitration under N.J.S.A.26:2SS-9 and as discussed above shall make an informational filing with the Department of the form of the identification card. This informational filing should be submitted to the Department at the following address:

New Jersey Department of Banking and Insurance
Attention: Life and Health Division
Self-Funded Health Benefits Plans – Arbitration
20 West State Street
Trenton, NJ 08625-0325

OUT-OF-NETWORK BILLING AND COST SHARING WAIVERS

Balance Billing for Inadvertent or Involuntary Out-of-Network Treatment

Covered persons shall be not be balance billed by any health care provider for inadvertent or involuntary out-of-network claims above and beyond the financial responsibility that would have been incurred if the same service had been provided by an in-network health care provider. See N.J.S.A. 26:2SS-7(a) and N.J.S.A. 26:2SS-8(c)(1).

Prohibitions on Waiver of Cost-Sharing

An out-of-network health care provider shall not, directly or indirectly, knowingly waive, rebate, give, pay, or offer to waive, rebate, give, or pay all or part of a covered person's deductible, copayment or coinsurance required under the person's health benefits plan as an inducement for the covered person to seek services from such out-of-network health care provider. See N.J.S.A. 26:2SS-15. A pattern of waiving, rebating, giving, or paying all or part of the deductible copayment or coinsurance by a provider shall be considered an inducement.

An out-of-network health care provider may waive, rebate, give, pay, or offer to waive rebate, give, or pay all or part of a covered person's deductible, copayment, or coinsurance required under the person's health benefits plan if:

- the waiver, rebate, gift, payment or offer thereof is not offered as part of any advertisement or solicitation;
- the out-of-network health care provider does not routinely waive, rebate, give, pay, or offer to waive rebate, give, or pay all or part of a covered person's deductible, copayment, or coinsurance required under the person's health benefits plan; and
- the out-of-network health care provider waives, rebates, gives, pays, or offers to waive rebate, give, or pay all or part of a covered person's deductible, copayment, or coinsurance required under the person's health benefits plan after determining in good faith that the covered person is in financial need; or fails to collect the covered person's deductible, copayment, or coinsurance after making reasonable collection efforts, which reasonable efforts shall not necessarily include initiating collection proceedings; or
- The waiver, rebate, gift, payment, or offer falls within any safe harbor under federal laws related to fraud and abuse concerning patient cost sharing, including as provided in any advisory opinions issued by the Centers for Medicare and Medicaid Services or the Office of Inspector General relating thereto.

DISCLOSURE AND TRANSPARENCY

Required Disclosures to Consumers Regarding Out-Of-Network Treatment

Carriers shall provide covered persons with clear and understandable descriptions of the benefits for services rendered by out-of-network health care providers that are covered under their specific health benefits plan, including benefits for such services when rendered on an emergency or urgent basis, for inadvertent out-of-network services, and where applicable, for voluntary out-of-network treatment as described below through and by the following dates: (1) a customized Summary of Coverage for Out-of-Network Treatment Under a Plan and Protections Under New Jersey Law ("Summary") – starting with plans issued or renewed on or after January 1, 2019; (2) an internet website – as of August 30, 2018; and (3) a telephone hotline – as of August 30, 2018.

The Department will develop a template Summary that carriers may wish to use to provide the transparency disclosures required by the Act. The template Summary will be attached to the Bulletin, when issued, and it will contain mandatory and optional charts with mandatory and variable text that provide the transparency disclosures required under the Act. The contemplated language to be included in the template Summary is attached to this synopsis as an Appendix.

Carriers that elect to use the template Summary should customize it based on the terms of the specific health benefits plan applicable to the covered person receiving the Summary. Carriers should provide the transparency disclosures upon the issuance of new plan, any material change to any aspects of the summarized benefits under an in-force plan, and upon request from a covered person. The Summary contains the following specific disclosures:

- How the plan covers medically necessary treatment on an emergency or urgent basis by out-of-network health care professionals and facilities, also known as involuntary out-of-network treatment;
- How the plan covers treatment by an out-of-network healthcare professional for services when a covered person uses an in-network health care facility (e.g. hospital, ambulatory surgery center, etc.) and, for any reason, in-network health care services are unavailable or rendered by that out-of-network provider in that in-network facility, including laboratory testing ordered by an in-network provider and performed by an out-of-network bio-analytical laboratory, also known as inadvertent out-of-network treatment;
- That a covered person's cost-sharing for inadvertent and involuntary out-of-network treatment is limited to the cost-sharing under the plan applicable for the same services when received in-network;
- A description of the ability of carriers to negotiate and settle with out-of-network health care providers to pay less than the amount billed for inadvertent and involuntary out-of-network treatment, and how that settlement may increase the covered person's cost sharing above the amount indicated in the initial EOB;
- A description of the right of carriers and out-of-network health care providers to enter into binding arbitration for inadvertent and involuntary out-of-network services to determine the amount to be paid by the carrier for the medical services where an agreement cannot be reached through negotiation and the provider does not accept the payment with the Pre-Arbitration EOB, including disclosures that the arbitration award will not increase the covered person's cost-sharing above the amount in the Pre-Arbitration EOB;
- How all plans will cover treatment from out-of-network health care providers if in-network health care providers are not available in accordance with the applicable network adequacy standards and that the ability to access this coverage is accessible by request for an in-plan exception, which is an adverse benefit determination subject to internal and external appeals;
- If the plan is a preferred provider organization plan ("PPO") or point of service plan ("POS") that covers treatment when a covered person voluntarily seeks to use out-of-network health care providers for the provision of covered services, known as voluntary out-of-network treatment, including: the cost-sharing applicable to voluntary out-of-network treatment and the carrier's basis for calculating the allowed charge;
- How to obtain more information from the carrier regarding whether a provider is in-network, examples of out-of-network costs, and how to estimate costs for out-of-network treatment for specific Current Procedural Terminology ("CPT") codes; and

- The internet website address(es) and telephone hotline number maintained by the carrier to provide information on out-of-network coverage and issues.

Carriers that elect to create their own disclosures must ensure that the above elements are contained in the disclosures.

Carriers are also required to maintain an internet website that provides:

- the same information as set forth above for each health benefits plan offered by the carrier in this State, See N.J.S.A. 26:2SS-6;
- a clear and prominent disclaimer that any estimates or examples provided by the carrier for out-of-network costs do not take into account the amounts that the covered person may have already paid for cost-sharing that accumulate toward the maximum out-of-pocket costs ("MOOP"), See N.J.S.A. 26:2SS-6; and
- a clear and prominent disclaimer that out-of-network arbitration is only mandatory with respect to services provided by a provider that is licensed or certified in New Jersey. See N.J.S.A. 26:2SS-3.

Carriers must also maintain a telephone hotline that is operated for at least 16 hours per day staffed with at least one live representative capable of responding to questions about network status and out-of-pocket costs. See N.J.S.A. 26:2SS-6(b)(7).

Please provide any feedback you wish the Department to consider concerning the implementation of the Act as described herein by e-mail to Denise M. Illes, Chief, Office of Regulatory Affairs, at advancenotice@dobi.nj.gov by [insert date one week from issuance], 2018. Thank you for your participation.

AV OON Bulletin Synopsis/Bulletins

APPENDIX

Disclosures to Covered Persons Regarding Out-Of-Network Treatment

The template summary of coverage for out-of-network treatment under a plan and protections under New Jersey Law will provide that:

- The summary provides only an overview of how a covered person's health benefit plan covers out-of-network treatment;
- It is only guidance to help a covered person understand their out-of-network benefits;
- It does not alter coverage in any way;
- The covered person should refer to their individual policy, group policy, certificate or evidence of coverage (if an employer group plan), or summary of benefits and coverages for more information about out-of-network benefits and about coverages and costs for in-network treatment; and
- For additional information, including whether a health care professional or facility is in-network or out-of-network, examples of out-of-network costs and estimates for specific services, the carrier should be contacted. The carrier should include a toll-free telephone number that will be active at least 16 hours a day and the hours of operation as well as a website address.

The template summary will be set forth in a table format, and will provide the following three mandatory disclosures concerning involuntary and inadvertent out-of-network treatment, and two optional disclosures depending on whether a policy covers voluntary out-of-network services.

Mandatory Disclosure: Coverage of Medically Necessary Treatment on an Emergency or Urgent Basis by Out-Of-Network Health Care Professionals/Facilities

What this Means:

- Emergency - You are covered for out-of-network treatment for a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of Substance Use Disorder such that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of immediate medical attention to result in: placing the health of the individual or unborn child in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. This includes any further medical examination and such treatment as may be required to stabilize the medical condition. This also includes if there is inadequate time to effect a safe transfer of a pregnant woman to another hospital before delivery or such transfer may pose a threat to the health or safety of the woman or unborn child.
- Urgent – You are covered for out-of-network treatment of a non-life-threatening condition that requires care by a health care professional within 24 hours.

Protections under NJ Law:

- Except as discussed below, you should not be billed by an out-of-network health care professional or facility, for any amount in excess of any deductible, copayment, or coinsurance amounts (also known as "cost-sharing") applicable to the same services when received in-network. If you receive a bill for any other amount, the carrier should be contacted at a specified number, and/or file a complaint with the Department of Banking and Insurance: www.state.nj.us/dobi/consumer.htm.
- Your carrier and the out-of-network health care professional/facility may negotiate and settle on an amount that is ultimately paid for the emergent/urgent medical services. If that negotiated amount exceeds what was indicated on the initial Explanation of Benefits, your out-of-pocket cost-sharing may increase above the amount indicated on the initial Explanation of Benefits. Your total final costs will be provided on the Final Explanation of Benefits if settled.
- If an agreement cannot be reached, your carrier or the out-of-network health care professional/facility may seek to enter into binding arbitration to determine the amount to be paid for the medical services. The amount awarded by the arbitrator may exceed what the carrier has already paid to the out-of-network health care professional/facility; however, any additional amount paid by the carrier pursuant to the arbitration award will not increase your cost-sharing above the amount indicated as your responsibility on the Pre-Arbitration Explanation of Benefits associated with the last payment made to the health care professional/facility before any arbitration. If arbitration is conducted, you will also receive a Final Explanation of Benefits that will show the total allowed charge for the service(s).

Mandatory Disclosure: Coverage of Inadvertent Out-Of-Network Services

What this means:

- You are covered for treatment by an out-of-network health care professional for covered services when you use an in-network health care facility (e.g. hospital, ambulatory surgery center, etc.) and, for any reason, in-network health care services are unavailable or provided by an out-of-network health care professional in that in-network facility. This includes laboratory testing ordered by an in-network health care professional and performed by an out-of-network bio-analytical laboratory (e.g., imaging, x-rays, blood tests, and anesthesia).

Protections Under NJ Law:

- Except as provided below, you should not be billed by an out-of-network health care professional or facility, for any amount in excess of any deductible, copayment, or coinsurance amounts (also known as "cost-sharing") applicable to the same services when received in-network. If you receive a bill for any other amount, please contact us at the number above, and/or file a complaint with the Department of Banking and Insurance: https://www.state.nj.us/dobi/consumer.htm
- Your carrier and the out-of-network health care professional/facility may negotiate and settle on an amount that is ultimately paid for the inadvertent out-of-network services. If that negotiated amount exceeds what was indicated on the initial Explanation of Benefits, your out-of-pocket cost-sharing may increase above the amount indicated on the initial

Explanation of Benefits. Your total final costs will be provided on the Final Explanation of Benefits if settled.

- If an agreement cannot be reached, your carrier or the out-of-network health care professional/facility may seek to enter into binding arbitration to determine the amount to be paid for the inadvertent out-of-network services. The amount awarded by the arbitrator may exceed what the carrier has already paid to an out-of-network health care professional/facility; however, any additional amount paid by the carrier pursuant to the arbitration award will not increase your cost-sharing above the amount indicated as your responsibility on the Pre-Arbitration Explanation of Benefits associated with the last payment made to the health care professional/facility before any arbitration. If arbitration is conducted, you will also receive a Final Explanation of Benefits that will show the total allowed charge for the service(s).

Mandatory Disclosure: Coverage of Treatment from Out-Of-Network Health Care Professionals/Facilities if In-Network Health Care Professionals/Facilities are Unavailable

What this means:

- Plans are required to have adequate networks to provide you with access to professionals/ facilities within certain time/distance requirements so you can obtain medically necessary treatment of all illnesses or injuries covered by your plan.

Protections under NJ Law:

- You can request treatment from an out-of-network health care professional/facility when an in-network health care professional/facility is unavailable through an appeal, often called a request for an "in-plan exception." Please see the Department of Banking and Insurance's guide at: https://nj.gov/dobi/appeal/.

Optional Disclosure: Add for Policies with Voluntary Out-of-Network Coverage

What this means:

- You are covered for treatment by an out-of-network health care professional/facility when you knowingly, voluntarily and specifically select an out-of-network health care professional/facility, even if you have the opportunity to be serviced by an in-network health care professional/facility. We will cover voluntary out-of-network services as follows: [*INSERT TEXT DESCRIBING COST-SHARING FOR CONSUMER WITH REGARD TO THE ALLOWED CHARGE*].
- Please be advised that the ALLOWED CHARGE (discussed above) is not the same as the amount billed by your Out-of-Network Health Care Professional/Facility, and is usually less. WE CALCULATE THE ALLOWED CHARGE AS FOLLOWS: [*INSERT TEXT SPECIFYING THE METHOD USED TO DETERMINE THE ALLOWED CHARGE If different sources for different types of services, please identify all sources by service type*].
- You will be RESPONSIBLE FOR PAYMENT OF: a) Your cost-sharing portion of the allowed charge as disclosed above; PLUS, b) the difference between our allowed charge and the amount the out-of-network health care professional/facility bills for the services (commonly referred to as the "balance bill").

Protections under NJ Law:

- Carriers must provide ready access to information about how to determine when a health care professional/facility is in-network. Please contact us if you have any questions about the status of a particular professional/facility. Additionally, health care professionals/facilities must disclose to you, in writing or on a website, the plans in which they participate as in-network providers. Note, indications that a professional/facility "accepts" a certain health plan does not necessarily indicate in-network status. So, when seeking treatment, you can check with both us and your prospective health care professional/facility.
- Carriers must provide a method to enable you to be able to calculate an estimate of out-of-network costs when voluntarily seeking to use an out-of-network health care professional/facility. YOU CAN CONTACT US VIA THE METHODS ABOVE TO OBTAIN MORE INFORMATION REGARDING THE ALLOWED CHARGES FOR SPECIFIC SERVICES IF YOU CAN PROVIDE A CURRENT PROCEDURAL TERMINOLOGY (CPT) CODE. If you do not have a CPT code, you can estimate your costs by: [*Insert text describing how the estimates can be calculated by both current and prospective members. This could be through reference to a proprietary calculator, or through reference to sources for carrier's allowed charges and public database of billed fees].*
- You can also visit our website above for examples of the average costs (allowed charge, billed amount, consumer responsibility without cost-sharing under plan) for ten more frequently billed out-of-network services.

Optional Disclosure: Add for Policies without Voluntary Out-of-Network Coverage

What this means:

- You are not covered for treatment by an out-of-network health care professional/facility when you knowingly, voluntarily and specifically select an out-of-network professional/facility for treatment when you have the opportunity to be serviced by an in-network healthcare professional/facility.

Protections Under NJ Law

- As discussed above, you can request treatment from an out-of-network health care professional/facility when an in-network health care professional/facility is unavailable through an appeal, called a request for "in-plan exception."