



State of New Jersey

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BULLETIN NO. 18-14

TO: ALL INSURANCE COMPANIES AUTHORIZED TO ISSUE HEALTH BENEFITS PLANS, HEALTH MAINTENANCE ORGANIZATIONS, HEALTH SERVICE CORPORATIONS, HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, MULTIPLE EMPLOYER WELFARE ARRANGEMENTS, THE STATE HEALTH BENEFITS PROGRAM, THE SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM, ENTITIES PROVIDING HEALTH BENEFITS PLANS, AND OTHER INTERESTED PARTIES

FROM: MARLENE CARIDE, COMMISSIONER

**RE: 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 (codified at N.J.S.A. 26:2SS-1 to -20), ("Act"), was enacted, and became effective on August 30, 2018. This Act enhances consumer protections from surprise bills for out-of-network health care services, in addition to making changes to several elements of New Jersey's health care delivery system. These improvements include transparency and various consumer disclosures, the creation of an arbitration system, and cost containment for out-of-network services. The Department of Banking and Insurance ("Department") is issuing this Bulletin to provide guidance to carriers,¹ health care providers, and other interested parties to help those entities meet their obligations under the Act, pending the adoption of rules. The Department anticipates proposing such rules in the near future.

¹ As defined in the Act, a "carrier" is an entity that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefits plan, including: an insurance company authorized to issue health benefits plans; a health maintenance organization; a health, hospital, or medical service corporation; a multiple employer welfare arrangement ("MEWA"); the State Health Benefits Program, and the School Employees' Health Benefits Program; or any other entity providing a health benefits plan. See N.J.S.A. 26:2SS-3.

The transparency provisions of the Act apply to all carriers operating in New Jersey with regards to health benefits plans issued in New Jersey. The claims processing and arbitration provisions of the Act apply to all policies issued by carriers without regard to whether the policy contains coverage for voluntary out-of-network benefits. Further, the claims processing and arbitration provisions of the Act apply when the out-of-network services were rendered on an inadvertent² and/or emergency or urgent basis³ (“involuntary”) (collectively, “inadvertent and/or involuntary out-of-network services”) in New Jersey and by a New Jersey licensed or certified health care provider (subject to limited exceptions for laboratory services further discussed herein) to a covered person under a health benefits plan issued in New Jersey. The claims processing and binding arbitration sections of the Act may also apply to self-funded health benefits plans that elect to be subject to the claims processing and arbitration provisions of the Act and that cover New Jersey residents.

The Act limits a covered person’s cost-sharing liability to the network level cost-sharing as applied to the allowed amount/charge⁴ when inadvertent and/or involuntary out-of-network services are rendered. Cost-sharing is the covered person’s network level deductible, copayments, or coinsurance, and does not refer to a specific dollar amount. It is important to note that a covered person’s cost-sharing liability under the Act is based upon the application of network cost-sharing, not a network level reimbursement amount, which will vary in amount by and among carriers and plans, and even within and among a carrier’s plans, depending on the in-network provider. If the covered person is covered by a tiered health benefits plan, the cost-sharing applied for inadvertent and/or involuntary out-of-network services should be the preferred, lowest cost tier. Providers are prohibited from balance billing a covered person for inadvertent and/or involuntary out-of-network services above the amount of the covered person’s liability based upon the application of network cost-sharing to the allowed charge/amount.

It is important to note that covered persons cannot waive their rights under the Act. The Act provides that a provider does not render a covered person’s decision to proceed with treatment from a provider a choice that was made “knowingly” simply by disclosing the provider’s network

² “Inadvertent out-of-network services” means health care services that are: covered under a managed care health benefits plan that provides a network; and provided by an out-of-network health care provider in the event that a covered person utilizes an in-network health care facility for covered health care services and, for any reason, in-network health care services are unavailable in that facility. “Inadvertent out-of-network services” shall include laboratory testing ordered by an in-network health care provider and performed by an out-of-network bio-analytical laboratory. See N.J.S.A. 26:2SS-3.

³ “Emergency or urgent basis” means all emergency and urgent care services including, but not limited to, the services required pursuant to N.J.A.C.11:24-5.3. See N.J.S.A. 26:2SS-3.

⁴ Allowed charge/amount means the allowance for the service as determined by the carrier.

status.⁵ See N.J.S.A. 26:2SS-3. As such, waivers provided to covered persons in situations where inadvertent and/or involuntary out-of-network services may be provided does not remove those services from the purview of the Act, and thus, providers must not balance bill covered persons for inadvertent and/or involuntary out-of-network services even if those covered persons sign waivers for, or consent to, those services.

While the provision of medically necessary services by an out-of-network urgent care or emergency facility clearly constitutes involuntary out-of-network services to which the arbitration provisions of the Act apply, it is important to note that any admissions into the same out-of-network facility resulting from the involuntary out-of-network services will also be subject to arbitration under the Act up to the point when the covered person can be safely transported to an in-network facility, and including the means of transfer between facilities. Since all plans require providers and covered persons to notify the carrier within a certain number of days upon a facility admission, the carrier will have knowledge of such an involuntary out-of-network admission and be able to engage in utilization management.⁶ If during such utilization management, the carrier authorizes a continued stay in the out-of-network facility past the date upon which the covered person can be safely transferred to an in-network facility, the services rendered after that determination will be considered an in-plan exception, and the services will not be subject to arbitration under the Act. If the carrier does not authorize the continued stay in the out-of-network facility and requires transfer, but the covered person elects to stay at the out-of-network facility, the services rendered after the date of safe transfer would be considered voluntary out-of-network services and are not subject to arbitration under the Act.

In totality, the Act both creates and modifies processes and requires carriers to take action with regard to the following, as briefly summarized below. Details regarding implementation of the Act's requirements are provided throughout the remainder of the Bulletin.

Claims Processing and Arbitration: The Act creates an arbitration process to resolve out-of-network billing disputes for inadvertent and/or involuntary out-of-network services. Where carriers and out-of-network health care providers cannot agree upon reimbursement for such services, an arbitrator will choose between the parties' final offers as provided herein. See N.J.S.A. 26:2SS-10. A self-funded plan may opt to be subject to the claims processing and arbitration provisions, as provided herein, and be subject to the same arbitration process as carriers in the

⁵ "Knowingly, voluntarily, and specifically selected an out-of-network provider" means that a covered person chose the services of a specific provider, with full knowledge that the provider is out-of-network with respect to the covered person's health benefits plan, under circumstances that indicate that covered person had the opportunity to be serviced by an in-network provider, but instead selected the out-of-network provider. See N.J.S.A. 26:2SS-3.

⁶ Carriers may engage in utilization management to the extent permitted by New Jersey law. For example, P.L. 2017, c. 28 limits a carrier's ability to engage in utilization management upon admissions for treatment of substance use disorders. These protections still apply and may lengthen the period of an involuntary out-of-network admission to which the arbitration provisions of the Act apply.

insured markets. See N.J.S.A. 26:2SS-9(d) and 10(f). However, a self-funded plan that opts to be subject to the claims processing and arbitration provision of the Act is not bound to the transparency disclosures and other sections of the Act. In the case of a self-funded plan, which does not elect to be subject to the claims processing and arbitration provisions of the Act, a covered person under that plan or an out-of-network health care provider may initiate arbitration, wherein the arbitrator will choose a final amount that the arbitrator determines is reasonable, which is binding on the covered person and the out-of-network health care provider but not on the self-funded health benefits plan that did not opt-in to arbitration. See N.J.S.A. 26:2SS-11.

Out-of-Network Billing: The Act prohibits providers from billing covered persons for inadvertent and/or involuntary out-of-network services for any amount above the amount resulting from the application of network level cost-sharing to the allowed charge/amount. See N.J.S.A. 26:2SS-7 to -9. The Act also prohibits out-of-network health care providers, except in certain circumstances, from directly or indirectly, knowingly waiving, rebating, giving, paying, or offering to waive rebate, give, or pay all or part of a covered person's deductible, copayment, or coinsurance required under the covered person's health benefits plan as an inducement for the covered person to seek services from that out-of-network health care provider. See N.J.S.A. 26:2SS-16.

Disclosure and Transparency: For managed care plans with a network, carriers are required to: maintain up-to-date website postings of network providers; provide clear and detailed information regarding how voluntary out-of-network services are covered for plans that feature out-of-network coverage; provide examples of out-of-network costs; provide treatment specific information as to estimated costs when requested by a covered person; and maintain a telephone hotline to address questions. See N.J.S.A. 26:2SS-6.

CLAIMS PROCESSING AND ARBITRATION

Processing of Claims for Inadvertent and/or Involuntary Out-of-Network Services 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/or involuntary out-of-network services.

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 and/or involuntary out-of-network services, 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 health care provider's billed charges exceed the amount that the carrier initially determined is the allowed charge/amount for those services and process the claim as follows:

- Remit, electronically or by certified mail, payment for its portion of the initial allowed charge/amount to the out-of-network health care provider with remittance advice, that either includes text or is accompanied by a separate document, which details:
 - information to identify the specific remittance advice, covered person, and impacted claims that have been determined to exceed the amount that the carrier has initially determined is the allowed charge/amount for those services, and to which the initial allowed charge/amount applies;
 - that the claim is for inadvertent and/or involuntary out-of-network services, that the carrier has concluded that the billed charges exceed the amount that the carrier initially determined is the allowed charge/amount for those services, and the methods to initiate negotiation, 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/amount;
 - that if the out-of-network health care provider does not accept the carrier's initial allowed charge/amount 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 receipt of the carrier's notification that it deemed that the out-of-network health care provider's billed charges exceed the amount that the carrier initially determined is the allowed charge/amount for those services;
 - that to exercise this right, the out-of-network health care provider must advise the carrier of its intent to reject the carrier's allowed charge/amount as payment in full by methods identified by the carrier, which must include certified mail, email, and online form submission, within 30 days of receipt of the carrier's notification that it deemed that the out-of-network health care provider's billed charges exceed the amount that the carrier initially determined is the allowed charge/amount for those services; and
 - that if the out-of-network health care provider does not contact the carrier within 30 days of receipt of the carrier's notification that it deemed that the out-of-network health care provider's billed charges exceed the amount that the carrier initially determined is the allowed charge/amount for those services, the out-of-network health care provider cannot seek redress through the arbitration process set forth in the Act; and

- Upon the issuance of the payment for its portion of the initial allowed charge/amount 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 be accompanied by a separate document, which details that:

- the claim is for inadvertent and/or involuntary out-of-network services and the carrier has concluded that the billed charges exceed the amount that the carrier initially determined is the allowed charge/amount for those services;
- 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/amount;
- the out-of-network health care provider can reject the carrier's initial allowed charge/amount as being considered payment in full;
- if the carrier's initial allowed charge/amount is rejected by the out-of-network health care provider as insufficient reimbursement, the amount of the allowed charge/amount may be subject to negotiation;
- if negotiation is pursued and is successful, the amount of the allowed charge/amount may increase, which will result in the carrier paying more and may increase the covered person's cost-sharing liability for the out-of-network claim;⁷
- if negotiation is unsuccessful, both the carrier and the out-of-network health care provider can seek to enter into arbitration;
- if negotiation is not pursued by the provider, this EOB becomes final and indicates the covered person's cost-sharing liability for the inadvertent and/or involuntary out-of-network services; and
- the covered person shall not be balanced billed by the out-of-network health care provider for the inadvertent and/or involuntary out-of-network services above the covered person's cost-sharing liability, as set forth in the EOB or subsequent EOBs, and any attempts by the out-of-network health care provider to balance bill the covered person above the covered person's cost-sharing liability should be reported to the carrier and a complaint filed with the appropriate provider's licensing board or the Department of Health, as appropriate.

It is the Department's expectation that out-of-network health care providers will bill the covered person for the covered person's cost-sharing liability for inadvertent and/or involuntary out-of-network services once. Thus, the covered person's cost-sharing liability will become due and payable upon acceptance of the initial allowed charge/amount, or upon issuance of an EOB upon the negotiated settlement/carrier's final offer payment made by the carrier as set forth below.

2) Negotiation:

If the out-of-network health provider rejects the initial allowed charge/amount, the Act provides that the allowed charge/amount is subject to negotiation between the carrier and the out-of-network health care provider for no more than 30 days following the date of receipt of the

⁷ Since network level cost-sharing is applied to the allowed charge/amount, an increase in the allowed charge/amount can result in increased cost-sharing liability depending on the processing of additional claims and the status of the covered person's satisfaction of their maximum out-of-pocket ("MOOP") liability.

carrier's notification that it deemed that the out-of-network health care provider's billed charges exceed the amount that the carrier initially determined is the allowed charge/amount for those services. As provided above, the out-of-network health care provider that is seeking to engage in negotiation must advise the carrier of its intent to reject the carrier's initial allowed charge/amount as payment in full within 30 days of receipt of the carrier's notification that it concluded that the billed charges exceed the amount that the carrier initially determined is the allowed charge/amount for those services. See N.J.S.A. 26:2SS-9. A provider's failure to do so will bar arbitration of the claim for involuntary and/or inadvertent out-of-network services.

When Settlement is Achieved: If a negotiated settlement as to the allowed charge/amount is reached within 30 days following the date of receipt of the carrier's notification that the provider's billed charges exceed the carrier's initial determination, the carrier must remit payment for the additional liability for its portion of the negotiated allowed charge/amount to the out-of-network health care provider within 30 days of settlement. The remittance advice to the out-of-network health care provider, which may be accompanied by a separate document, if needed, and a second EOB to the covered person, which may be accompanied by a separate document, if needed, must include text, which details that:

- the final allowed charge/amount 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 claim for inadvertent and/or involuntary out-of-network services;
- the amounts of the initial allowed charge/amount, initial carrier payment, and the covered person's cost-sharing liability based upon those amounts;
- the amounts of the negotiated allowed charge/amount, revised carrier payment, and the covered person's final cost-sharing liability for the inadvertent and/or involuntary out-of-network services as of the time of reprocessing;
- the additional amount paid by the carrier, calculated as the difference between the initial carrier payment and the revised carrier payment; and
- the covered person shall not be balanced billed by the out-of-network health care provider for the inadvertent and/or involuntary out-of-network services above the covered person's cost-sharing liability as set forth in this second EOB, and any attempts by the out-of-network health care provider to balance bill the covered person above the covered person's cost-sharing liability should be reported to the carrier and a complaint filed with the provider's licensing board or the Department of Health, as appropriate.

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:

- notify the out-of-network health care provider of the carrier's final offer allowed charge/amount;
- remit additional payment of its portion of the final offer allowed charge/amount to the out-of-network health care provider; and
- issue a second EOB, which may be accompanied by a separate document, if needed, to the covered person, and remittance advice or a similar notice, which may be accompanied

by a separate document, if needed, to the out-of-network health care provider, that sets forth the following:

- That a negotiated settlement of the allowed charge/amount was not achieved;
- The amounts of the initial allowed charge/amount, initial carrier payment, and the covered person's cost-sharing liability based upon those amounts;
- The amounts of the carrier's final offer allowed charge/amount, revised carrier payment, and the covered person's final cost-sharing liability for the inadvertent and/or involuntary out-of-network services as of the time of reprocessing;
- If the carrier's final offer allowed charge/amount is higher than the initial allowed charge/amount, then the carrier must advise that the amount of the allowed charge/amount has increased and that the covered person's total cost-sharing liability 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, calculated as the difference between the initial carrier payment and the revised carrier payment;
- That the covered person's cost-sharing liability will not increase further, even if the carrier or out-of-network health care provider enter into binding arbitration; and
- That the covered person shall not be balanced billed by the out-of-network health care provider for the inadvertent and/or involuntary out-of-network services above the covered person's cost-sharing liability, as set forth in the second EOB and any attempts by the out-of-network health care provider to balance bill the covered person above the covered person's cost-sharing liability should be reported to the carrier and a complaint filed with the provider's licensing board or the Department of Health, as appropriate.

As already noted, it is the Department's expectation that out-of-network health care providers will bill the covered person for the covered person's cost-sharing liability for inadvertent and/or involuntary out-of-network services once. Thus, if the provider rejects the carrier's initial allowed charge/amount as payment in full, the covered person's cost-sharing liability will become due and payable upon the negotiated settlement/carrier's final offer payment. The covered person's cost-sharing liability will not increase further, even if the arbitration award increases the allowed charge/amount for the claim for inadvertent and/or involuntary out-of-network services.

Arbitration of Claims for Inadvertent and/or Involuntary Out-of-Network Services⁸

⁸ Other mechanisms of appeal and arbitration provided under New Jersey law continue to exist and are available for use by providers and covered persons, such as the Independent Health Care Appeals Program for medical necessity issues and the New Jersey Program for Independent Claims Payment Arbitration ("PICPA") established by the Health Claims Authorization, Processing and Payment Act, P.L. 2005, c. 352. However, PICPA and arbitration under the Act are mutually exclusive, i.e. a matter that is eligible for arbitration under the Act because it is a claim for inadvertent and/or involuntary out-of-network services must not be submitted to PICPA (voluntary arbitration for all other types of healthcare reimbursement disputes). For assistance as to which

This arbitration process applies to all claims for inadvertent and/or involuntary out-of-network services provided in New Jersey by a provider that is licensed or certified by New Jersey with dates of service on and after August 30, 2018, under health benefits plans issued in New Jersey (subject to some exception for laboratory services as discussed below), and to self-funded health benefits plans that opt-in under the Act and cover New Jersey residents. N.J.S.A. 26:2SS-10 and 11. For claims for inadvertent and/or involuntary out-of-network services 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 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 claims for inadvertent and/or involuntary out-of-network services rendered on or after August 30, 2018.⁹

For claims for inadvertent and/or involuntary out-of-network services that are not resolved as paid-in-full pursuant to the claims and negotiation processes set forth above, the carrier, which includes self-funded plans that elect to be subject to the claims processing and arbitration provisions of the Act pursuant to N.J.S.A. 26:2SS-11(f), or an out-of-network health care provider can request to enter into binding arbitration within 30 days of the out-of-network health care provider's receipt of the carrier's notification that sets forth the carrier's final offer if:

- the difference between the carrier's final offer allowed charge/amount and the out-of-network health care provider's final offer 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;
 - experimental or investigational;
 - cosmetic; or

arbitration or appeal mechanism applies, see the "Appeal and Arbitration Processes Grid," attached hereto as Attachment A.

⁹ For claims for inadvertent and involuntary out-of-network services that are ripe for arbitration on or before the date that this Bulletin is issued and that otherwise comply with the Act, but that fail to meet a technical or timing requirement contained in this Bulletin, the Department's out-of-network arbitration vendor, which will be MAXIMUS, Inc. for the first year after the effective date of the Act, will accept the requests for arbitrations notwithstanding a failure to comply with the timing and technical requirements set forth in this Bulletin. However, arbitration requests for those claims for inadvertent and involuntary out-of-network services that occur after the date of this Bulletin, should comply with the requirements as set forth herein, or the request may be rejected by MAXIMUS, Inc.

- medical or dental for which the carrier should have authorized services to be performed by an out-of-network health care 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 the New Jersey Program for Independent Claims Payment Arbitration ("PICPA") established by the Health Claims Authorization, Processing and Payment Act ("HCAPPA"), P.L. 2005, c. 352. to administer the Out-of-Network Arbitration System ("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 will be initiated by submitting a completed "Application for Arbitration of Payment for Inadvertent, Emergency or Urgent Out-of-Network Health Care Services" form ("OON Arbitration Application"), attached hereto as Attachment B (https://nj.gov/dobi/division_insurance/oonarbitration/requestform.pdf), directly to MAXIMUS through its website.¹⁰

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 will 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 covered person was enrolled in the health benefits plan at the time that the inadvertent and/or involuntary out-of-network service was rendered;
- An out-of-network health care provider, who is licensed or certified in New Jersey, rendered a covered service to a covered person in New Jersey under the health benefits plan, and the services provided were inadvertent and/or involuntary out-of-network services. For laboratory testing by a laboratory licensed in New Jersey, this includes when tests are ordered by an in-network health care provider and any necessary services for the test (e.g. blood draw) are rendered to the covered person in New Jersey without regard to the situs of the laboratory performing the testing;

¹⁰ Currently, MAXIMUS will be accepting OON Arbitration Applications through its established website for PICPA at <https://njpica.maximus.com/njportal>. Parties requesting OON Arbitration should submit the OON Arbitration Application, attached as Attachment B, and accompanying documents pursuant to the instructions set forth on this website. However, MAXIMUS is in the process of creating an OON Arbitration specific portal for future OON Arbitration requests. Upon implementation of an OON Arbitration specific portal on MAXIMUS's website, all subsequent requests for OON Arbitration should be submitted through the new OON Arbitration portal.

- The disputed amount—the difference between the carrier’s and out-of-network health care provider’s final offers—is \$1,000 or more. Claim aggregation is permitted for the same covered person experiencing multiple services rendered by the same out-of-network health care provider during the course of the same admission in an in-network facility or the same emergent/urgent event;
- The initiating party’s final offer for the allowed charge/amount is specified in the request, which for a carrier must be the amount set forth in the second EOB;
- The OON Arbitration Application includes, or the covered person has previously submitted, a fully-executed “Consent to Representation in Appeals of Utilization Management Determinations and Authorization for Release of Medical Records in UM Appeals and Independent Arbitration of Claims” form in the event that 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, with the OON Arbitration Application and the applicable fee.

MAXIMUS will reject an OON Arbitration Application received in excess of 30 days after the provider’s receipt of the carrier’s notification of its final offer allowed charge/amount. MAXIMUS shall also reject a request for OON Arbitration upon a demonstration by the carrier that the provider did not notify of its rejection of the initial allowed charge/amount within thirty (30) days of receipt of the carrier’s notification that the out-of-network health care provider’s billed charges exceed the amount that the carrier initially determined is the allowed charge/amount for those services.

Within seven business days of receipt of an OON Arbitration Application, MAXIMUS will acknowledge receipt of the application to the parties and provide notice of any deficiencies in the OON Arbitration Application or accompanying documents, and of the procedures for correcting such deficiencies. If the initiating party fails to correct any deficiencies within 15 days, the OON Arbitration 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 timeframes provided in that notice.

If an OON Arbitration Application is rejected based upon information submitted with the OON Arbitration Application, MAXIMUS will retain the initiating party’s review fee and refund the arbitration fee. If the OON Arbitration Application is initially accepted, but later rejected as ineligible based upon information submitted in whole or in part by the non-initiating party, MAXIMUS will 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 Application and accompanying documents, the arbitrator will issue a decision subject to the following requirements:

- The decision must be in writing and issued by the arbitrator;¹¹
- 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 out-of-network health care provider prevails in the arbitration, the carrier must remit payment of the difference between its portion of its final offer allowed charge/amount 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 the covered person's cost-sharing liability. 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 arbitration decision, pursuant to HCAPPA. 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.

The carrier must notify the covered person of the results of the arbitration award upon payment of an arbitration award, if applicable, but no later than 30 days from the date of the arbitration decision. The carrier must notify the covered person of the arbitration result through the issuance of a final EOB, that includes text, or is accompanied by a separate document, that advises of the following:

- the arbitration decision has been issued;
- the amount of the arbitration award for final allowed charge/amount, any revised carrier payment, based upon the arbitrator's award, if applicable, and the covered person's final cost-sharing liability for the claim as of the time of reprocessing, which shall not be greater

¹¹ N.J.S.A 26:2SS-10 provides the following: “[t]he [D]epartment shall contract, through the request for proposal process, every three years, with one or more entities that have experience in health care pricing arbitration. The arbitrators shall be American Arbitration Association certified arbitrators. The [D]epartment may initially utilize the entity engaged under the “Health Claims Authorization, Processing, and Payment Act,” P.L.2005, c.352 (C.17B:30-48 et seq.), for arbitration under this act; however, after a period of one year from the effective date of this act, the selection of the arbitration entity shall be through the Request for Proposal process.” This provision allows for the use of MAXIMUS and its current staff of arbitrators during the first year; subsequent Request for Proposal processes shall require compliance with the remaining provisions regarding certification of such arbitrators.

than the covered person's cost-sharing liability, based upon the carrier's final offer allowed charge/amount as disclosed in the second EOB;

- the amount, if any, paid by the carrier, based upon the difference between the final offer allowed charge/amount 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 liability as a result of the arbitration award;
- that the covered person shall not be balanced billed by the out-of-network health care provider for the inadvertent and/or involuntary out-of-network services above the covered person's cost-sharing liability, as set forth in the second and final EOB, and any attempts by the out-of-network health care provider to balance bill the covered person above the covered person's cost-sharing liability should be reported to the carrier and a complaint filed with the provider's licensing board or the Department of Health, as appropriate.

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

For any self-funded health benefits plan, which covers New Jersey residents, that does not opt to participate in the OON Arbitration, the member of the self-funded plan or the out-of-network health care provider may request binding arbitration for claims for inadvertent and/or involuntary out-of-network services, if there is no resolution of a payment dispute within 30 days after the member is sent a bill for the services. Specifically, an out-of-network health care provider may bill the member once upon the initial adjudication of the claim for inadvertent and/or involuntary out-of-network services by the self-funded plan. Thereafter, a 30-day negotiation period is commenced, during which time, the out-of-network health care provider must not collect or attempt to collect reimbursement from the member, including through the initiation of collection proceedings. After the expiration of the 30-day negotiation period, either the out-of-network health care provider or the member may initiate arbitration. The out-of-network health care provider may not balance bill the member or initiate collection activity until the provider has filed a request for arbitration. Arbitrations under this section will be administered by the Department's OON Arbitration vendor, as discussed above. Voluntary out-of-network claims are not eligible for arbitration.

Participation in OON Arbitration must be requested by submitting a completed OON Arbitration Application, attached hereto as Attachment B, directly to MAXIMUS.¹² 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, 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 emergency or urgent services rendered by an out-of-network health care provider;

¹² See fn10 above.

- The member was enrolled in the self-funded plan at the time the inadvertent and/or involuntary services were rendered;
- The member has been balance billed by an out-of-network health care provider for the inadvertent and/or involuntary services rendered;
- The OON Arbitration Application includes, or the member has previously submitted, a fully-executed “Consent to Representation in Appeals of Utilization Management Determinations and Authorization for Release of Medical Records in UM Appeals and Independent Arbitration of Claims” form in the event that the member’s confidential information accompanies the arbitration request; and
- The party initiating the arbitration request has submitted all information requested by MAXIMUS, as necessary, with the OON Arbitration Application and the applicable fee.

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

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.

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

- The decision must be in writing and issued by an arbitrator;¹³
- The decision must award an amount that the arbitrator determines is reasonable for the inadvertent and/or involuntary out-of-network service(s);
- 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 member, which can be demonstrated by total family income below 250% of the Federal Poverty Level.
- The decision will not award legal fees or costs; and
- The decision will only be binding on the member and the out-of-network 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 for the inadvertent and/or involuntary out-of-network service(s).

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

Under current rules at N.J.A.C. 11:22-8, all carriers, third party administrators, or other entities, that provide or administer a self-funded health benefits plan in New Jersey must 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 is permitted to contract with an administrator, agent, contractor, or other vendor to issue the cards; however, the entity responsible

¹³ See fn11 above.

for administration of the self-funded plan that is licensed in New Jersey remains responsible for the proper issuance of the cards and for their compliance. The Act requires the addition of whether the plan has opted-in to the arbitration provisions under the Act. Thus, issuance of identification cards compliant with the Act 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, MEWA, 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 that the self-funded health benefits plan has elected to participate in the OON Arbitration, pursuant to N.J.S.A.26:2SS-9 and 10, which is to be located on the front of the card below or adjacent to "SELF-FUNDED," and should state: "NJ Arbitration – Yes as of [insert effective date (after which all claims for inadvertent and/or involuntary out-of-network services incurred are subject to arbitration) that is at least two weeks after mailing of card]."

Self-funded health benefits plans that do not elect to participate in OON Arbitration pursuant to the Act are not required to provide any additional statements on the identification cards that indicate their participation status.

Additionally, every entity that provides or administers a self-funded health benefits plan that elects to be subject to OON Arbitration under N.J.S.A.26:2SS-9 and 10 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 Services

As discussed throughout and provided in the Act, covered persons shall not be balance billed by any health care provider for inadvertent and/or involuntary out-of-network services above and beyond the financial responsibility that would have been incurred if the same service(s) 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 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;

OR

- the waiver, rebate, giving, 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.

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:

- a customized “Summary of Coverage for Out-of-Network Treatment Under a Plan and Protections Under New Jersey Law” (“Summary”)—attached as Attachment C—starting with plans issued or renewed on or after January 1, 2019;
- an internet website – as of August 30, 2018; and
- a telephone hotline – as of August 30, 2018.

Attached hereto as Attachment C is a template Summary that carriers may wish to use to provide the transparency disclosures required by the Act. The template Summary contains mandatory and optional charts with mandatory and variable text that provide the transparency disclosures required under the Act. Carriers that elect to use the Summary should customize it based upon 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 a 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 services;
- 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 out-of-network health care 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;
- That a covered person’s cost-sharing liability for inadvertent and/or involuntary out-of-network services is limited to the network level cost-sharing under the plan;
- 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/or involuntary out-of-network services, and how that settlement may increase the covered person’s cost-sharing liability above the amount indicated in the initial EOB;¹⁴
- A description of the right of carriers and out-of-network health care providers to enter into binding arbitration for inadvertent and/or involuntary out-of-network services to determine the amount to be paid by the carrier for the such services where an agreement cannot be reached through negotiation and the provider does not accept the payment with the second EOB, including disclosures that the arbitration award will not increase the covered person’s cost-sharing liability above the amount in the second EOB;
- How all plans 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 a provider through a request for an in-plan exception. Note that the denial of such request is an adverse benefit determination subject to internal and external appeals as discussed in Attachment A;
- 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-

¹⁴ See fn7 above.

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/amount;

- 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 New Jersey. 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 their cost-sharing liability that accumulate toward the MOOP. See N.J.S.A. 26:2SS-6;
- 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; and
- information that enables prospective members to calculate the anticipated out-of-pocket costs for voluntary out-of-network services in a geographical region or zip code. See N.J.S.A. 26:2SS-6(b)(4).

The provision of CPT code-specific disclosures of out-of-network allowed charges/amounts are only required for current covered persons and may be placed on members-only portions of the carrier's website. See N.J.S.A. 26:2SS-6(b)(1), (2), (3), (5), and (7).

Carriers must also maintain a telephone hotline that is operated for at least 16 hours per day and 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).

11/20/18
Date



Marlene Caride
Commissioner

ATTACHMENT A

Appeal and Arbitration Processes Grid

Process Name	Issues that can be Resolved	Who can Initiate	Who Decides	Citations
<p>Independent Health Care Appeals Program (established by Health Care Quality Act)</p> <p>IHCAP</p>	<p>Medical Necessity of services, including whether a service is experimental, investigational, cosmetic, and dental rather than medical, whether an in-plan exception is warranted, and whether services are required on an emergency or urgent basis</p>	<p>Covered person, or provider acting with consent of the covered person</p>	<p>Independent Utilization Review Organizations under contract with the Commissioner, currently Island Peer Review Organization and Permedion</p>	<p>N.J.S.A. 26:2S-11 and 12, N.J.A.C. 11:24-8.7 and N.J.A.C. 11:24A-3.6</p>
<p>Program for Independent Claims Payment Arbitration (established by Health Claims Authorization, Processing and Payment Act)</p> <p>PICPA</p>	<p>What is the appropriate payment for a covered service rendered by a provider, excludes disputes that can be submitted to the IHCAP and OON Arbitration</p>	<p>Network providers - any type of covered service, Out-of-network providers – services that do not qualify as inadvertent or emergency or urgent</p>	<p>Nationally recognized independent arbitration organization under contract with the Commissioner, currently MAXIMUS</p>	<p>N.J.S.A. 17:48-8.4e(2), N.J.S.A. 17:48A-7.12e(2), N.J.S.A. 17:48E-10.1e(2), N.J.S.A. 17B:26-9.1e(2), N.J.S.A. 17B:27-44.2e(2), N.J.S.A. 26:2J-8.1e(2), N.J.S.A. 17:48F-13.1e(2) and N.J.A.C. 11:22-1.13</p>
<p>Out-of-Network Inadvertent and</p>	<p>Whether the final offer of the carrier or the final</p>	<p>Out-of-network providers and carriers</p>	<p>Entity with experience in health care pricing</p>	<p>N.J.S.A. 26:2SS-10</p>

<p>Emergent/Urgent Arbitration (established by Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act)</p> <p>OON Arbitration</p>	<p>offer of the out-of-network provider is the appropriate reimbursement for inadvertent or emergency or urgent services rendered by the out-of-network provider where the person is covered by an insured plan, MEWA, SHBP/SEHBP or by a self-funded plan that opts to participate in the binding OON Arbitration process,</p> <p>Or</p> <p>What is a reasonable payment for inadvertent, emergency or urgent (involuntary) services rendered by the out-of-network provider when the person is covered by a self-funded plan that does not opt to participate in the binding OON Arbitration process</p>	<p>for insured plans, MEWAs, SHBP/SEHBP, out-of-network providers and plan administrators for self-funded plans that opt in to OON Arbitration, and covered persons and out-of-network providers for self-funded plans that do not opt in to OON Arbitration</p>	<p>arbitration and using American Arbitration Association certified arbitrations that is under contract with the Department, initially MAXIMUS</p>	
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ATTACHMENT B



New Jersey Department of Banking and Insurance

**APPLICATION FOR ARBITRATION OF PAYMENT FOR INADVERTENT,
EMERGENCY OR URGENT OUT-OF-NETWORK HEALTH CARE SERVICES**

In accordance with P.L. 2018, c. 32 (N.J.S.A. 26:2SS-1 to -20)

N.J.S.A. 26:2SS-1 to -20 permits health care providers, carriers and, in certain instances, covered persons to apply for arbitration when they cannot agree on the appropriate reimbursement for health care services rendered by an out-of-network health care provider on an inadvertent¹, emergency or urgent basis. This is the Out-of-Network Arbitration System (OON Arbitration).

Use this form to request OON Arbitration only if:

1. The covered person to whom health care services were rendered was covered under a network-based health benefits plan that was issued by a carrier in New Jersey;
2. The health care service was rendered in New Jersey by a New Jersey licensed facility or practitioner;
3. The health care provider that rendered the health care services is not in the network of the covered person's health benefits plan;
4. The covered person received out-of-network services from: (a) an out-of-network health care provider at an in-network health care facility on an inadvertent basis; (b) an out-of-network health care facility and/or practitioner on an emergency or urgent basis; or, (c) an out-of-network bio-analytical laboratory that performed a test that was ordered by an in-network health care provider and the covered person was not provided the opportunity to select an in-network bio-analytical laboratory; and
5. There is no dispute as to whether the health care services provided were Medically Necessary², cosmetic, experimental or investigational, or warranted an in-plan exception and the services are otherwise covered under the terms of the covered person's health benefits plan.

This application for arbitration can be submitted by a health care provider, by the carrier (which, for purposes of this process includes the SHBP, the SEHBP, a MEWA, and any other payor providing a self-funded health benefits plan that opts into arbitration), or by a person covered by a self-funded health benefits plan in New Jersey that did not opt to participate in arbitration. However, a health benefits plan does not include coverage through Medicare or Medicaid.

Self-funded Plans

Employers that self-fund may elect to use the OON Arbitration. If a self-funded plan chooses to use the OON Arbitration, the plan will be bound by the decision of the arbitrator. Persons covered by self-funded plans that do not opt into OON Arbitration and the providers who treat such persons can still request OON Arbitration but the arbitrator's decision will not be binding on the self-funded plan and will not be based on the final offers of the provider and the self-funded plan. The arbitrator's decision will be binding on the covered person and the provider.

Release of Medical Records

If a health care provider needs to provide medical records to support a claim in OON Arbitration, the health care provider must submit a completed *Consent to Representation in Appeals of Utilization Management Determinations and Authorization for Release of Medical Records in UM Appeals and Independent Arbitration of Claims*. A covered person does not need to submit this form. The form is available at https://www.state.nj.us/dobi/division_insurance/drcorner.htm.

Other Issues

If dissatisfied with a claims determination, but the situation does not meet the requirements for a OON Arbitration, there are other processes available for health care providers or consumers to use. See https://www.state.nj.us/dobi/division_insurance/drcorner.htm.

Submit this completed form and attachments to the OON Arbitration vendor's website.

¹ N.J.S.A. 26:2SS-3 defines inadvertent to refer to services provided by an out-of-network provider in an in-network facility where in-network services are unavailable in the facility for any reason.

² N.J.S.A. 26:2SS-3 defines medically necessary as a health care service that a health care provider, exercising prudent clinical judgment, would provide to evaluate, diagnose or treat an illness, injury, disease or its symptoms, and that is consistent with generally accepted medical practice, clinically appropriate, not primarily for the convenience of the covered person or health care provider, and not more costly than an alternative service or services at least as likely to produce equivalent therapeutic or diagnostic results.



New Jersey Department of Banking and Insurance

**APPLICATION FOR ARBITRATION OF PAYMENT FOR INADVERTENT,
EMERGENCY OR URGENT OUT-OF-NETWORK HEALTH CARE SERVICES**

In accordance with P.L. 2018, c. 32 (NJ.S.A. 26:2SS-1 to -20)

Applicant's Name (please print): _____

Applicant is/represents the (check one): Provider Carrier TPA Employer Patient

A. Provider Information	1.Provider Name:		2.TIN/NPI:	
	3.Provider Group (if applicable):			
	4.Contact Name:		5.Title:	
	6.Contact Address:			
	7.PH:	8.Fax:	9.Email:	
B. Patient & Coverage	1.Patient Name:		2.ID:	
	3.Subscriber's Name:		4.ID:	
	5.Coverage Type (check one): <input type="checkbox"/> Individual/Nongroup <input type="checkbox"/> Group/Employer-based <input type="checkbox"/> SHBP/SEHBP			
	6.Coverage is provided/administered by (check one, and add the appropriate name below): <input type="checkbox"/> Carrier <input type="checkbox"/> TPA <input type="checkbox"/> Employer (Plan Sponsor) – select this if there is no TPA or Carrier indicated Name:			
	7. a. Is the group coverage a self-funded health benefits plan? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable b. If yes, has the plan sponsor agreed to this Independent Arbitration? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
C. Claim Information	1.Date of Service:		2.Service Type (check one): <input type="checkbox"/> Emergency/Urgent <input type="checkbox"/> Inadvertent	
	3.Claim #:		4.Authorization #:	
	5.List the codes in dispute:		6.Attach the following: <input type="checkbox"/> Claim <input type="checkbox"/> Initial EOB/Carrier's Initial Offer <input type="checkbox"/> Additional EOBs / Carrier's Final Offer <input type="checkbox"/> Health Care Provider's Final Offer	
			7.Specify one: <input type="checkbox"/> The Consent to Representation in Appeals of Utilization Management Determinations and Authorization for Release of Medical Records in UM Appeals and Independent Arbitration of Claims is attached, with medical records <input type="checkbox"/> Medical records have not been submitted and are not needed	

Applicant's Signature: _____ Date: ____/____/____

ATTACHMENT C

Disclosures to Covered Persons Regarding Out-of-Network Treatment

THIS SUMMARY ONLY PROVIDES AN OVERVIEW OF HOW A COVERED PERSON’S HEALTH BENEFITS PLAN COVERS OUT-OF-NETWORK TREATMENT. IT IS ONLY GUIDANCE TO HELP A COVERED PERSON UNDERSTAND THEIR OUT-OF-NETWORK BENEFITS. THIS SUMMARY DOES NOT ALTER YOUR COVERAGE IN ANY WAY.

THE COVERED PERSON SHOULD REFER TO THEIR INDIVIDUAL POLICY, GROUP POLICY, CERTIFICATE OR EVIDENCE OF COVERAGE (IF EMPLOYER GROUP PLAN), OR SUMMARY OF BENEFITS AND COVERAGES FOR MORE INFORMATION ABOUT YOUR OUT-OF-NETWORK BENEFITS AND ABOUT COVERAGES AND COSTS FOR IN-NETWORK TREATMENT.

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 - PLEASE CONTACT US AT:

[INSERT TOLL-FREE TELEPHONE NUMBER THAT WILL BE ACTIVE AT LEAST 16 HOURS A DAY and HOURS OF OPERATION], OR

VISIT OUR WEBSITE AT: *[INSERT SPECIFIC URL FOR WEBSITE PAGE ADDRESSING OUT-OF-NETWORK BENEFITS FOR APPLICABLE NEW JERSEY HEALTH BENEFITS PLAN].*

[The following three charts are mandatory disclosures.]

Your Policy Covers:	What this Means:	How Am I Protected by NJ law?
Medically Necessary Treatment on an Emergency or Urgent Basis by Out-Of-Network Health Care Professionals/Facilities	<p>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 affect 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.</p> <p>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.</p>	<p>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, please contact us at the number above, and/or file a complaint with the Department of Banking and Insurance: www.state.nj.us/dobi/consumer.htm.</p> <p>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 liability 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.</p> <p>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</p>

	<p>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 <u>will not</u> increase your cost-sharing liability above the amount indicated as your responsibility on the second 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/amount for the service(s).</p>
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Your Policy Covers:	What this Means:	How Am I Protected by NJ law?
<p>Inadvertent out-of-network services</p>	<p>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).</p>	<p>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</p> <p>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 liability 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.</p> <p>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 <u>will not</u> increase your cost-sharing liability above the amount indicated as your responsibility</p>

		on the second 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/amount for the service(s).
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Your Policy Covers:	What this Means:	How Am I Protected by NJ law?
Treatment from out-of-network health care professionals/facilities if in-network health care professionals/facilities are unavailable.	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.	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/ .

[Option 1 – Add for Policies with Voluntary Out-of-Network Coverage]

Your Policy Covers:	What this Means:	How Am I Protected by NJ law?
Voluntary out-of-network services	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. <u>We will cover voluntary out-of-network services as follows: [INSERT TEXT DESCRIBING COST-SHARING FOR CONSUMER WITH REGARD TO THE ALLOWED CHARGE/AMOUNT].</u>	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.

	<p>Please be advised that the ALLOWED CHARGE/AMOUNT (discussed above) is <u>not</u> the same as the amount billed by your Out-of-Network Health Care Professional/Facility, and is usually less. WE CALCULATE THE ALLOWED CHARGE/AMOUNT AS FOLLOWS: <i>[INSERT TEXT SPECIFYING THE METHOD USED TO DETERMINE THE ALLOWED CHARGE/AMOUNT If different sources for different types of services, please identify all sources by service type].</i></p>	<p>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 CHARGE/AMOUNTS 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: <i>[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 charge/amounts and public database of billed fees].</i></p>
	<p>You will be RESPONSIBLE FOR PAYMENT OF: a) Your cost-sharing portion of the allowed charge/amount as disclosed above; PLUS, b) the difference between our allowed charge/amount and the amount the out-of-network health care professional/facility bills for the services (commonly referred to as the “balance bill”).</p>	<p>You can also visit our website above for examples of the average costs (allowed charge/amount, billed amount, consumer responsibility without cost-sharing under plan) for ten more frequently billed out-of-network services.</p>

[Option 2 – Add for Policies without Voluntary Out-of-Network Coverage]

Your Policy DOES NOT Cover:	What this Means:	How Am I Protected by NJ law?
Voluntary out-of-network services	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.	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."