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.*]

<table>
<tr><th>Your Policy Covers:</th><th>What this Means:</th><th>How Am I Protected by NJ law?</th></tr>
<tr><td rowspan="3">Medically Necessary Treatment on an Emergency or Urgent Basis by Out-Of-Network Health Care Professionals/Facilities</td><td rowspan="3">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.

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.</td><td>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.</td></tr>
<tr><td>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.</td></tr>
<tr><td>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</td></tr>
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		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 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).

Your Policy Covers:	**What this Means:**	**How Am I Protected by NJ law?**
Inadvertent out-of-network services	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).	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 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.
		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 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).

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/.

[*<u>Option 1</u> – 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</u>: [*INSERT TEXT DESCRIBING COST-SHARING FOR CONSUMER WITH REGARD TO THE ALLOWED CHARGE/AMOUNT*].	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.

	Please be advised that the ALLOWED CHARGE/AMOUNT (discussed above) <u>is 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: [*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*].	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: [*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]*.
	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").	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.

[*<u>Option 2</u> – 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."