**DISCLAIMER**

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he New Jersey Hospital Association’s (NJHA) Out-of-Network Implementation Toolkit (hereinafter “materials”) are intended to be tools that hospitals may use to implement and comply with the “Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act.” The information provided in these materials should not be relied upon or regarded as legal advice. No specific representation is made, nor should be implied, nor shall NJHA or any other party involved in creating, producing or delivering this material be liable in any manner whatsoever for any direct, incidental, consequential, indirect or punitive damages arising out of your use of these materials. NJHA makes no warranties or representations, express or implied, as to the accuracy or completeness of the information contained or referenced herein. This publication is provided “AS IS” WITHOUT WARRANTY OF ANY KIND, EITHER EXPRESSED OR IMPLIED, INCLUDING, BUT NOT LIMITED TO, THE IMPLIED WARRANTIES OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, OR NON-INFRINGEMENT. Some jurisdictions do not allow the exclusion of implied warranties, so the above exclusion may not apply to you. All images and information contained in these materials are copyrighted and otherwise proprietary. No use of this information is permitted without the prior written consent of NJHA. If you have other questions or concerns, please contact NJHA’s Legal Affairs at 609.275.4089.

**Out-of-Network Disclosure Requirements**

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overnor Murphy signed the “Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act” (“OON”) June 1, 2018.

The law requires general acute care hospitals, satellite emergency departments, hospital-based off-site ambulatory facilities that perform ambulatory surgical procedures and ambulatory surgery facilities to, among other things, provide patients with multiple notices when they contact the hospital or surgery center to schedule an appointment.

This resource provides information concerning the notices that must be given to individuals with a fully insured, New Jersey-issued plan, a State Health Benefits Plan, a School Employees’ Health Benefits Plan or members of self-funded insurance plans.

**Disclosure Prior To Scheduling Covered Services:** Disclosures are never required for emergent or urgent services. Additionally, these disclosures are not required if the patient has the following types of plans:

Medicaid

Medicare

Medicare Advantage

Accident Only Plans

Disability Plans

Long-Term Care Plans

Tricare

Workers’ Compensation

Auto Medical Insurance

Personal Injury Protection (PIP)

Dental Insurance

Hospital Confinement Indemnity

***In-Network Facility (Fully Insured or Self-Funded Opt-In)***

When a patient contacts the facility to schedule an appointment for a **non-emergency** or **elective covered procedure,** they must first be informed:

* *The facility is in-network.*
* *The patient should contact the physician ordering the healthcare services to determine whether that physician is in-network or out-of-network.*
* *Where they can find information on the insurance plans that the hospital’s employed and contracted physicians participate with. If the patient prefers a hard copy, it must be provided.*
* *They will not be expected to pay more than the in-network copayment, deductible, or coinsurance unless they specifically select an out-of-network physician, which can lead to higher out-of-pocket costs.*
* *Any in-network medical bills that a patient receives for more than the patient’s copayment, deductible, or coinsurance should be reported to the patient’s health insurance plan and the relevant regulatory agency, such as the Department of Banking and Insurance.*
* *Any network status change for the hospital or surgery center must be shared with the patient prior to the scheduled date of the healthcare services.*

***Out-of-Network Facility (Fully Insured and Self-Funded Opt-In)***

Prior to scheduling a **non-emergent** or **elective** service for a patient that has a health insurance plan that is a fully insured, New Jersey-issued plan or is a self-funded plan that elects to be subject to the OON law and your facility is out-of-network with that plan, you must notify the patient:

* The facility is out-of-network with their health insurance plan.
* They could be charged more than the in-network copayment, coinsurance or deductible.
* They could be charged for the amount between what the insurance company pays the facility and what the facility bills the patient for the services.
* They should check with the physician ordering the healthcare services to determine if that physician is in-network or out-of-network with the patient’s health insurance plan.
* How to find out if any physician who is reasonably expected to provide services to the patient participates in their health insurance plan.

***Self-Funded Plans that Do Not Opt-In***

Prior to scheduling an appointment for a **non-emergent** or **elective service,** a person with a self-funded health benefits plan that did not opt-in and elect to subject itself to the OON law, your facility must notify the patient:

* Certain healthcare services may be provided on an out-of-network basis, including those services associated with the facility;
* The patient may have a financial responsibility for the services provided by an out-of-network physician, hospital or surgery center that exceeds their copayment, deductible or coinsurance;
* The patient may be responsible for any costs that exceed the amount paid or reimbursed by their insurance plan; and
* The patient should contact their self-funded health plan sponsor for more information on potential out-of-pocket expenses.

**Sample Language for Use When Scheduling Patient Appointments**

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ew Jersey’s “Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act” (“OON”) requires that consumers receive certain information from providers prior to scheduling an appointment for **non-emergency** or **elective covered services** if they have certain kinds of insurance. For example, consumers with a fully insured, New Jersey-issued plan, the State Health Benefits Plan, the School Employees’ Health Benefits Plan or a self-funded plan that opts in and elects to subject itself to the law all have the right to certain information.

These notice requirements do not apply to the following types of coverage which are subject to different laws:

Medicaid

Medicare

Medicare Advantage

Accident Only Plans

Disability Plans

Long-Term Care Plans

Tricare

Workers’ Compensation

Auto Medical Insurance

Personal Injury Protection (PIP)

Dental Insurance

Hospital Confinement Indemnity

This resource includes sample language that may assist you when speaking with patients to ensure that you cover all notice requirements. You may use this language as is or modify the language according to your facility’s needs. However, you must ensure that all of the disclosures are made.

***Sample Script Language – Language that applies to all patients***

* *This is [Hospital].*
* *[Hospital] is in network or [Hospital name] is out-of-network with the [insert health insurance plan name] (state whether the hospital is in network or out of network with a particular health insurance plan).*
* *Prior to receiving services, it is important that you contact your insurance company to determine your potential out-of-pocket costs under your insurance plan and to double-check that your individual healthcare services are covered and authorized.*
* *Not all of the physicians who work in the [Hospital] participate in the same health insurance plans that the hospital accepts.*
* *We have a list of all employed and contracted physicians who practice at [Hospital] on our website. You may contact the physicians directly to see if they participate in your health insurance plan.*
* *You should check with the physician who ordered the healthcare services and ask whether the physician is in network or out of network with your health insurance plan. You should also ask if there are additional physicians who may be involved with your care.*
* *The physicians bill separately. So, you may receive more than one bill for your healthcare services.*
* *If a physician is in network, you should never be charged more than your in-network copayment, coinsurance or deductible.*
* *If an in-network provider charges more than your in-network copayment, coinsurance or deductible, you should notify your health insurance plan and the Department of Banking and Insurance/Department of Health.*

***Additional Disclosures – In-network***

* *Because* *[Hospital name] is in network, you will not pay more than your in-network copayment, coinsurance or deductible for the hospital’s services.*
* *If [Hospital]’s network status changes with your health insurance plan prior to your scheduled appointment, [Hospital] will notify you.*

***Additional Disclosures – Out-of-network***

* *Because [Hospital name] is out of network, you may pay more than your in-network co-payment, coinsurance or deductible for the services received or performed at this facility.*
* *You may be responsible for any difference between what your insurance company pays [Hospital name] for the service and what [Hospital name] charges.*
* *If you wish to receive services at [Hospital name], first please contact your insurance company to determine if you have an out-of-network benefit option. If you do, you should ask what your potential out-of-pocket costs may be and double-check that your services will be covered. If you do not have an out-of-network benefit option, you will be responsible for all charges.*

***Additional Disclosures – Self-Funded Plans that did not opt-in***

* *You have a health insurance plan that is self-funded.*
* *Self-funded insurance plans are not required to follow the “Out-of-Network” law.*
* *We must advise you that any services you receive at [Hospital name] may be out-of-network with your health insurance plan.*
* *Because of this, you may pay more than your co-payment, coinsurance or deductible for services received or performed at this facility.*
* *You may also have to pay the balance above any amount that your insurance plan paid for the services.*
* *If you wish to receive services at [Hospital], please contact your insurance plan to find out if you have an out-of-network benefit option. If you do have an out-of-network benefit option, you should inquire about your potential out-of-pocket costs and double-check that the healthcare services will be covered. If you do not have an out-of-network benefit option, you will be responsible for all charges.*