The New Jersey Hospital Association’s (“NJHA”) Federal/State Surprise Billing Requirements Toolkit (“Materials”) is intended to serve as tools that member hospitals may use to implement and comply with the requirements of both the New Jersey “Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act” and the federal “No Surprises Act.” Member hospitals should not regard any information provided in these Materials as specific legal advice, and they should consult with their own legal counsel for additional guidance as appropriate. NJHA and any other party involved in creating, producing, or delivering these Materials shall not be liable for any direct, incidental, consequential, indirect, or punitive damages arising out of the use of these Materials. The further distribution of these Materials is prohibited without the prior written consent of NJHA.

The information contained within the Materials is provided to assist members’ compliance efforts to protect consumers from surprise medical bills as required by law effective Jan. 1, 2022. However, it must be noted that the federal law requirements were issued as interim final rules—that are subject to change and are only accurate as of the date released.

**Federal/State Disclosure Notices   
on Surprise Billing Protections and In-Network Status**

New Jersey’s Out-of-Network law and the federal No Surprises Act include requirements for disclosure forms to help consumers understand how they are protected against surprise medical bills.

The federal form on consumer rights and protections is an educational piece that includes definitions, a summary of when protections apply, and sources for additional information.

The New Jersey forms not only educate consumers on surprise medical bills, but they also provide details on how to learn more about potential out-of-pocket costs. New Jersey law has different disclosure requirements for instances when patients are fully-insured or self-funded.

Both laws also have notice and consent requirements that providers must give to individuals who are self-pay, uninsured, or who actively choose to use an out-of-network provider. These requirements are addressed separately in the Federal/State Surprise Billing Notice and Consent Resource tool.

While the federal rules include model language that can be used to meet the disclosure form requirements, the rules also state that providers aren’t obligated to use such model language, especially if there is a state form that has been adopted.

*New Jersey has not yet determined whether it will develop a state-specific document for disclosures or if such document is developed, the extent to which its language will apply to the various disclosure methods. Given that CMS indicated use of the model notice would meet the good faith effort standard, NJHA suggests that providers use CMS’ model disclosure notice in conjunction with the existing State forms until further information is available.*

**FACILITY IN-NETWORK DISCLOSURE**

***{Patient name}* and *{health benefits plan}***

* *{Facility's name}* is in-network for the health benefits plan named above and your financial responsibility to this facility will be no greater than your in-network copayment, deductible, and/or coinsurance amount.
* You should contact the health care professional, such as your doctor, or the physician assistant or advance practice nurse who ordered the services, to determine if they are in­ network or out-of-network for your health benefits plan.
* In some cases, health care professionals other than the one ordering the service may provide and bill for care in this facility. You can expect for services to be provided by *{Facility must insert the names of health professionals reasonably anticipated to provide services}.* You can access information regarding the health benefits plans that these health care professionals participate in on *{facility's name}* website at *{website address}.* If you do not have internet access, a copy of this information will be provided to you upon request by {facility's name}.
* If you receive any bills from in-network providers for more than your in-network copayment, deductible, and/or coinsurance amount, you should report this information to your insurance carrier and, if the bill is from *{facility's name},* to the Department of Health at (800) 792-9770. If the bill is from a health care professional, you should report this information to the appropriate professional licensing board in the Division of Consumer Affairs, Department of Law and Public Safety at (973) 504-6200.

The amount you owe an in-network provider will not be more than any in-network copayment, deductible, coinsurance amount per your health benefits plan.

* If you specifically select an out-of-network provider, you will be asked to sign an acknowledgement of out-of-network provider services, which may exceed your in-network copayment, deductible, and/or coinsurance amount.
* You should contact your health benefits plan for information regarding your copayment, deductible and/or coinsurance amount. Contact information is typically found on the card provided to you by your health benefits plan.
* *{Facility's name}* staff will notify you in the event the in-network status of *{facility's name}*

changes before services are provided.

I **agree that I have read and understand this form and have been provided a copy of it.**

|  |  |  |
| --- | --- | --- |
| **Patient's Signature** |  | **Date** |

**SELF-FUNDED PLAN IN-NETWORK DISCLOSURE**

***{Patient Name}* and *{self-funded plan}***

* *{Facility's name}* is in-network for the self-funded plan named above and your financial responsibility to this facility will be no greater than your in-network copayment, deductible, and/or coinsurance amount.
* You should contact the health care professional, such as your doctor, or the physician assistant or advance practice nurse who ordered the services, to determine if they are in-network or out-of-network for your self-funded plan.
* In some cases, health care professionals other than the one ordering the service may provide and bill for care. You can expect for services to be provided by *{Facility must insert the names of health professionals reasonably anticipated to provide services}.* You can access information regarding the health benefits plans that these health care professionals participate in on *{facility's name}* website at

*{website address}.* Services may be provided on an out-of-network basis in regard to your self-funded plan. If you do not have internet access, a copy of this information shall be provided to you upon request by {facility's name}.

* If you receive any bills from in-network providers for more than your in-network copayment, deductible, and/or coinsurance amount, you should report this information to your self-funded plan administrator and, if the bill is from *{facility's name},* to the Department of Health at (800) 792-9770. If the bill is from a health care professional, you should report this information to the appropriate professional licensing board in the Division of Consumer Affairs, Department of Law and Public Safety at (973) 504-6200.
* The amount you owe an in-network provider will not be more than any in-network copayment, deductible, coinsurance amount per your health benefits plan.
* If you specifically select an out-of-network provider, you will be asked to sign an acknowledgement of out-of-network provider services, which may exceed your in-network copayment, deductible, and/or coinsurance amount.
* You should contact your self-funded plan administrator for information regarding your copayment, deductible and/or coinsurance amount and whether or not they have opted into in-network coverage for out-of-network services provided inadvertently or in an emergency or urgent basis. Billing disputes with self-funded plans that have opted into in-network coverage for services rendered in an emergency or on an urgent basis may be resolved through arbitration. Contact information is typically found on the card provided to you by your self-funded plan.
* *{Facility's name}* staff will notify you in the event the in-network status of *{facility's name}* changes before services are provided.

**I agree that I have read and understand this form and have been provided a copy of it.**

|  |  |  |
| --- | --- | --- |
| **Patient's Signature** |  | **Date** |