

CENTRAL JERSEY HEALTH INSURANCE FUND
2026 RISK MANAGEMENT PLAN

BE IT RESOLVED that the following shall be the Fund's Risk Management Plan for the 2026 Fund year:

1.) **COVERAGE OFFERED**

- Medical

The Fund offers a "point of services" and "open access" plan designs. These plans have both in network and out of network benefit. The Fund can offer other plans as may meet the needs of the members. Starting in 2012, the Fund also offers "low cost plans" to allow members options to comply with contribution requirements under Chapter 78 and for those covered under Chapter 44. Included as options are a health savings account-consumer directed health plan, a core PPO program, a buy up PPO program, and the plans for those covered under Chapter 44. For Medicare aged retirees, the Fund also offers fully insured "Medicare Advantage" plans.

- Dental

The Fund offers customized dental plans as required by the members.

- Prescription

The Fund offers customized prescription plans as required by the members, including plans that are coordinated with the low cost medical plan options. For Medicare retirees, "Employer Group Waiver Plans" are also offered.

- Vision

The Fund offers customized vision plans as required by the members.

2.) **LIMITS OF COVERAGE**

Limits of coverage vary by member plan design.

3.) **RISK RETAINED BY THE FUND**

The Fund takes no risk on Medicare Advantage and Employer Group Waiver Plan fully-insured policies purchased for Medicare retirees.

Pre-Medicare retirees and active employees and their dependents are covered by self-insured plans. Risk retained by the Fund for these plans is summarized as follows:

Medical and Prescription – For all members with such coverage except Lakewood Township:

- **Specific Coverage:** The Fund self-insures for the first \$400,000 per person per agreement year and obtains reinsurance through its membership in the Municipal Reinsurance Health Insurance Fund “MRHIF” for claims in excess of its self-Insured Retention “SIR” to an unlimited maximum per person per contract period (incurred in 12 months paid in 24 months).
- **Aggregate Coverage:** The Fund does not purchase aggregate coverage and retains the risk for medical, prescription, dental and vision claims except those claims that may be reimbursed under the specific Coverage listed above.
- Specific Limit Unlimited
- Basis: Incurred 12 months, paid 24 months.
- Dental Aggregate Retention: None – Self-insured with all risk retained by Fund
- Vision Aggregate Retention: None – Self-insured with all risk retained by Fund

Extra contractual claims are excluded from reinsurance coverage.

4.) **RISK RETAINED BY LOCAL UNITS – APPLICABLE TO LAKEWOOD TOWNSHIP ONLY – NO RISK RETAINED BY HEALTH INSURANCE FUND (9/1/18-12/31/2026)**

Medical and Prescription:

- Specific Retention: \$200,000
- Aggregate Retention: \$20,845,137
- Specific Limit Unlimited
- Aggregate Limit \$1,000,000, Medical and Rx
- Basis: Incurred 48 months, paid 12 months (run out claims and IBNR retained by Lakewood Township)
- Stop Loss Carrier: Symetra

5.) **ASSUMPTIONS AND METHODOLOGY TO CALCULATE CLAIM RESERVES.**

The Fund complies with statutory accounting standards and establishes reserves on the probable total claim costs at conclusion. Each month, the accrual in the general ledger for claim reserves, including IBNR, is adjusted based on earned underwriting income and the number of months since the inception of the Fund year. This accrual is the adjusted at the end of the year in accordance with the actuary's projections.

6.) METHODS OF ASSESSING CONTRIBUTIONS TO MEMBERS

At least one month before the end of the year, the Fund adopts a budget for the upcoming year based on the most recent census. Per covered person rates are computed for each line of coverage for each Fund member, and are approved by the Fund as a part of the budget adoption and rate certification process. These rates are used to compute the members' monthly assessment based on the updated census, and are mailed to the members approximately 15 days before the beginning of the month. Rates may include loss ratio adjustments of up to +2.5% depending upon member loss ratios over the past 2.5 years prior to the renewal. The billing also includes the member's updated census for verification each month by the local entity. Retroactive adjustments for enrollment changes are limited to 2 months. Former employees (COBRA, Conversion and some retirees) and, in some cases, Dependent Age 31 participants, are billed directly by the Fund.

Should there be a need to enroll or terminate an employee past 60 days due to a missed open enrollment period or a qualified life event, the member must submit this request in writing. The Fund Small Claims Committee will anonymously review each request, including the fiscal impact to the Fund. The Committee will approve/deny the request within 45 days.

Given its large size and its preference to be individually rated, medical and Rx rates for Lakewood are based upon their own claims experience and stop loss arrangements. As such, the Lakewood is solely responsible for funding its claims, owns all surplus, and would be responsible for its own deficits.

7.) COVERAGE PURCHASED FROM INSURERS AND PARTICIPATION IN THE MUNICIPAL REINSURANCE HEALTH INSURANCE FUND (MRHIF)

The Fund provides coverage on a self-insured basis, and secures excess insurance to cap the Funds' specific (i.e. per covered person per policy year) retention. The Fund is a member of the Municipal Reinsurance Health Insurance Fund (MRHIF). The MRHIF retains claims above the Fund's local specific retention and purchases an excess insurance policy that is filed with the Department of Banking and Insurance in accordance with the applicable regulations.

8.) THE INITIAL AND RENEWAL RATING METHODOLOGIES

Upon application to the Fund, the prospective member's benefit program is reviewed by the actuary to determine its projected claim cost. In this evaluation, the actuary takes into consideration:

- a.) age/sex factor as compared to the average for the existing Fund membership;

- b.) the plan of benefits for the prospective member; and
- c.) loss data if available.

The actuary then recommends a relativity factor to the Fund's base rates. This recommendation requires Fund approval before the prospective member is admitted to the Fund.

Rates for all members are adjusted at the beginning of each Fund year to reflect the new budget. The Fund may also adopt mid Fund year rate changes to reflect changes in plan design, participation in lines of coverage, or a budget amendment.

Unless otherwise authorized as part of the offer of membership, when a member joins during a FUND year, the member's initial rates are only valid through the end of the then current FUND year at which time the rates are adjusted for all members to reflect the new budget. Prospective members may be offered entry rates of up to eighteen (18) months to allow for the alignment of renewals with the fiscal years of the FUND or of the entity.

Loss experience used by the Fund to determine loss ratio adjustments will be made available twice per year to members at no additional cost. "Loss experience data" is defined as monthly claims and assessments for a three year period including de-identified specific claims at 50% of the Fund's self insured retention. Requests for additional claims data can be considered based upon the availability of data, the feasibility of extracting the data, and the reimbursement to the Fund or its vendors of data extraction and formatting costs. Additionally, if a member terminates a line of coverage but continues membership for other lines of coverage, an increase may be applied to remaining lines of coverage, and it shall not be eligible for membership in the dropped line of coverage for a three year period.

9.) RATING PERIODS

All rating periods for municipal members coincide with the Fund year while rating periods for school members coincide with their fiscal year (July 1 to June 30).

10.) FACTORS IF RATES FOR MEMBERS JOINING THE FUND DURING A FUND YEAR ARE TO BE ADJUSTED.

Unless otherwise authorized as part of the offer of membership, where a member joins during a Fund year, the member's initial rates are only valid through the end of that Fund year or, for schools, fiscal year, at which time the rates are adjusted for all members to reflect the new budget.

11.) PROVISION FOR PPOs, etc.

The Fund offers employees the option of selecting various plans depending upon member bargaining agreements. Generally, it is the policy of the Fund to encourage selection of lower cost plan designs as opposed to traditional indemnity plans, and the Fund provides promotional material to assist members in employee communication programs concerning optional plan designs.

12.) OPEN ENROLLMENT PROCEDURES

Open enrollment periods shall be scheduled by the Fund at least yearly for each member and as is otherwise required to comply with plan document requirements and to effectuate plan design, network changes, and plan migrations that may take place.

13.) COBRA AND CONVERSION OPTIONS

The Fund provides COBRA coverage at a rate equal to the member's current rate and benefit plan design, plus the appropriate administrative charge. The Fund has arranged for a COBRA administrator to enroll eligible participants and to collect the premium. Where provided for in a member's plan document, the Fund provides a conversion option at rates established by the Fund. Unless otherwise specified in the member's plan document, the conversion option duplicates the conversion option offered by the SHBC. The Fund's coverage for individuals covered under COBRA or conversion options shall terminate effective the date the member withdraws from the Fund, or otherwise ceases to be a member of the Fund.

14.) DISCLOSURE OF BENEFIT LIMITS

The Fund discloses benefit limits in plan booklets provided to all covered employees.

15.) PARTICIPATION RULES WHEN ALL OR PART OF THE PREMIUM IS DERIVED FROM EMPLOYEE CONTRIBUTIONS

All assessments, including additional assessments and dividends, are the responsibility of the member, not the employee or former employee. Employee contributions, if any, are solely an internal policy of the member which shall not impact on the member's obligations to the Fund or confer any additional rights to the employees. Where the Fund directly bills an employee, (i.e. COBRA, etc.), this shall be considered as a service to reduce the member's administrative burden, and the member shall be responsible in the event of non-payment.

16.) RETIREES

The Fund duplicates coverage for eligible retirees and provides "Medicare Advantage" plans for Medicare aged retirees. The Fund's coverage of a retiree shall terminate effective the date the member local unit withdraws from the Fund, or otherwise ceases to be a member of the Fund.

17.) NEWBORN CHILDREN

All plan documents will have the following language:

"You may remove family members from the policy at any time, but you may only add members within sixty (60) days of the change in family status (marriage, birth of a child, etc.). It is your responsibility to notify your employer of needed changes. If family members cease to be eligible, claims will not be paid. The actual change in coverage (and the corresponding change in premium) will not take place until you have formally requested that change. Newborn children, but not grandchildren of an eligible employee, shall be automatically covered

from birth for (60) days, even if not enrolled within the required sixty (60) days. In the event of an eligible dependent giving birth to a child, (a grandchild) benefits for any hospital length of stay in connection with childbirth for the mother or newborn grandchild will apply for up to 48 hours following a vaginal delivery, or 96 hours following a cesarean section. However, the mother's or newborn grandchild's attending provider, after consulting with the mother, may discharge the mother or her newborn grandchild earlier than 48 hours (or 96 hours as applicable). Pursuant to N.J.A.C. 11:15-3.6 (d) 17, automatic coverage of a newborn child or an adopted child is provided for a period of 60 days from the date of birth or the date of adoption.”

18.) PLAN DOCUMENT

The Fund prepares a detailed plan document for each member local unit (or each employee bargaining group within a member local unit as the case may be), and an employee handbook provides a summary of the coverage provided by the plan. Each booklet (or certificate) shall contain at least the following information and be provided to all covered employees within thirty (30) days of coverage being effective.

A.) General Information

- * Enrollment procedures and eligibility.
- * Dependent eligibility.
- * When coverage begins.
- * When can coverage be changed.
- * When does coverage end.
- * COBRA provisions.
- * Conversion privilege
- * Enrollment forms and instructions.

B.) Benefits

- * Definitions.
- * Description of benefits.
- * Eligible services and supplies.
- * Deductibles and co-payments.
- * Examples as needed.
- * Exclusions.
- * Retiree coverage, before age 65 or after (if any)

C.) Claims Procedures

- * Submission of claim.
- * Proof of loss.
- * Appeal procedures. This shall be in accordance with applicable governing law. See also Plan Document and FUND Risk Management Plan and Bylaws

D.) Cost Containment Programs

- * Pre-admission.
- * Second surgical opinion.
- * **Case Management**
- * Other cost containment programs
- * Application and level of employee penalties.

19.) PROCEDURES FOR THE CLOSURE OF FUND YEARS

Approximately every six months after the end of a Fund year, the Fund evaluates the results to determine if dividends or additional assessments are warranted. Most claims are paid within twelve months of year end, and at that time the Fund begins to consider closing the year, unless excess insurance recoveries are pending or litigation is likely.

Fully insured plans are not considered in surplus retention. Entities with only Medicare Advantage/Employer Group Waiver Programs are not included in closed year balance shares.

When the Fund determines that a Fund year should be closed:

- * A reserve is established by the actuary to cover any unpaid claims or IBNR
- * The Fund decides on the final dividend or supplemental assessment.
- * A closure resolution is adopted transferring all remaining assets and liabilities of that Fund year to the "Closed Fund Year/Contingency Account".
- * Each member's pro rata share of the residual assets are computed and added to its existing balance in the Closed fund Year/Contingency Account. Any member who has withdrawn from the Fund shall receive its remaining share of the Closed fund Year/Contingency Account six years after the date of its withdrawal.

20.) "RUN-IN" or "RUN-OUT" LIABILITY

The Fund covers the "run-out" liability of all members - i.e., liability for claims incurred but not reported by a former Fund member during the period it was a member. Upon approval of the Executive Committee, the Fund may also cover the run-in liability of a perspective member (i.e., the liability for claims incurred but not reported by a prospective member in connection with the provision of health benefits during the period prior to joining the Fund). When the Fund covers run-in liability, the prospective member shall be assessed the expected ultimate cost of run-in claims, as certified by the Fund's actuary and approved by the Executive Committee. The assessment shall be paid entirely within the Fund year the member joined the Fund.

21) CLAIMS, OPERATIONS **AND ENROLLMENT AUDITS**

The Fund retains a claim auditor experienced in auditing self-insured claims and operations. Claims and/or operational audits will be performed after the first year of operation and at least every three (3) years thereafter.

The FUND may require enrollment audits for new and existing members to ensure that benefits are paid only for persons meeting eligibility requirements.

22.) CLAIM APPEALS AND INDEPENDENT REVIEW ORGANIZATIONS

If an appeal to the Executive Committee results in a decision is to deny a claim, the appeal shall be subject to the “adverse benefit determination” appeal process that is required pursuant to applicable law. The plan participant (hereinafter sometimes referred to as “claimant”) shall at that time be advised that the adverse benefit determination may be appealed to the Fund's Independent Review Organization (“IRO”). The claimant's identity shall be revealed only upon the written request of the claimant. A copy of such written request with respect to disclosure of the claimant's name shall be sent to the Program Manager.

a. An appeal of an adverse benefit determination must be filed by the claimant within four (4) months from the date of receipt of the notice of the adverse benefit determination. The claimant shall submit a written request to the Program Manager to appeal an adverse benefit determination and/or final internal adverse benefit determination made by the TPA and the written request, shall be accompanied by a copy of the determination letter issued by TPA.

1. The Program Manager will conduct a preliminary review within five (5) business days of the receipt of the request for an external review. There is no right to an external review if (i) the claimant is or was not eligible for coverage at the time in question or (ii) the adverse benefit determination or final internal adverse benefit determination is based upon the failure of the claimant or covered person to meet requirements for eligibility under the Plan. The Program Manager shall notify the claimant if (a) the request is not eligible for external review; (b) that additional information is needed to make the request complete and what is needed to complete the request; or (c) the request is complete and is being forwarded to the IRO.

2. The Program Manager shall then forward an eligible, complete request for external review to the IRO designated by the Fund who shall be required to conduct its review in an impartial, independent and unbiased manner and in accordance with applicable law.

3. The assigned IRO will provide timely written notice to the claimant of the receipt and acceptance for external review of the claimant’s request and shall include a statement that the claimant may submit, in writing and within ten (10) business days of the receipt of the notice, additional information which shall be considered by the IRO when conducting the external review. Upon receipt of any information submitted by the claimant, the IRO, within one (1) business day, shall forward the information to the Program Manager who may reconsider the adverse benefit

determination or final internal adverse benefit determination and, as a result of such reconsideration, modify the adverse benefit determination or final internal adverse benefit determination. The Program Manager shall provide prompt written notice of any such modification to the claimant and the IRO.

4. The Program Manager, within five (5) business days of the assignment of the IRO, shall deliver to the IRO any documents and information considered in making the adverse benefit determination or the final internal adverse benefit determination. The IRO may terminate the external review and decide to reverse the adverse benefit determination or final internal adverse benefit determination if the Program Manager does not provide such information in a timely manner. In such event, the IRO shall notify the claimant and the Program Manager of the decision within one (1) business day.

5. The IRO shall complete the external review and provide written notice of its final external review decision within forty-five (45) days of the receipt of the request for the external review. In the case of a request for expedited external review of an adverse benefit determination or final internal adverse benefit determination where delay would seriously jeopardize the life or health of the claimant or the ability to regain maximum function, the IRO shall provide notice of the final external review decision as expeditiously as possible but in no event more than 72 hours after the receipt of the request for an expedited external review. If the notice is not in writing, the IRO must provide written confirmation of the decision to the claimant and the Program Manager within 48 hours after providing that notice in the case of an expedited external review. The IRO shall deliver notice of its final external review decision to both the claimant and the Program Manager for all external reviews conducted. The notice of decision shall contain:

(i) a general description of reason for the external review with sufficient information to identify the claim, claim amount, diagnosis and treatment codes and reason for previous denial;

(ii) the date the IRO was assigned and date of the IRO's decision;

(iii) references to the documentation/information considered;

(iv) a discussion of the rationale for the IRO's decision and any evidence-based standards relied upon in making the decision;

(v) a statement that the decision is binding on the claimant and the Fund subject to the claimant's right to seek judicial review of the same; and

(vi) that the claimant may contact the New Jersey health insurance consumer assistance office at NJ Department of Banking and Insurance, 20 West State Street, PO Box 329, Trenton, NJ 08625, phone (800) 446-7467 or (888) 393-1062 (appeals) website:

<http://www.state.nj.us/dobi/consumer.htm>

23.) ENROLLMENTS AND TERMINATIONS PAST 60 DAYS

Enrollments and terminations can be processed up to 60 days in the past. Should there be a need to enroll or terminate an employee past 60 days due to a missed open enrollment period or a qualified life event, the member must submit this request in writing. The Fund Small Claims

Committee will anonymously review each request, including the financial impact to the Fund. The Committee will approve/deny the request within 45 days.

24.) PARTIAL MONTH ENROLLMENTS

When processing enrollments and terminations, the Fund will charge a member for a full month rate for an employee that is enrolled between the 1st and the 15th of the month, but will charge the member in the following month if an enrollment occurred between the 16th and the 31st of the month. If a member should term between the 1st and the 15th of the month, the Fund will not charge the member a rate for the enrollment, but will charge a full month rate if a member terms between the 16th and the 31st of the month.

25.) MEDICARE ADVANTAGE/EGWP ONLY

The Fund may offer retiree coverage with a fully insured Medicare Advantage and/or Employer Group Waiver Program membership to an entity that does not have its active members in the Fund. The carrier will provide the Fund with a per employee, per month cost for a plan that matches equal to, or better to the current retiree plan. The Fund may add additional expenses to the price per employee. The entity would be required to sign an Indemnity and Trust agreement.

26.) QUALITY AND CLINICAL PLAN MANAGEMENT

The FUND shall have right to review, evaluate, and then implement certain Quality and Clinical Management programs related to the Medical, Pharmacy and Dental plans, as may be warranted from time to time, to address new and emerging issues related to the effective administration of the FUND. None of the programs shall constitute a change in benefit and shall not increase participant cost sharing. These programs may include, but are not limited to, Pharmacy and Medical quality and utilization programs that require a plan member to participate in a program intended to manage quality and improve outcome. If adopted by the FUND, such programs shall apply to all members of the FUND. The FUND shall utilize a formulary of preferred medications. The formulary will change from time to time as managed by the FUND's contracted Pharmacy Benefit Manager. Any changes to the formulary impacting a plan member will be addressed through advance notice to plan members. There will always be alternative medications available in each therapeutic class.

- Drug Utilization Management - The FUND may adopt or amend drug utilization management programs intended to impact the appropriate use of medications. These may include and are not limited to step therapy, generics preferred, formulary, retail network, prior authorization, and other programs provided for by the FUND's contracted Pharmacy Benefit Manager.
- Medical Care Management - The FUND may adopt or amend medical management plans intended to ensure member safety and efficacy of the health care program. This may include and not be limited to programs provided by the FUND's contracted Third-Party Administrator or others that can administer such programs.

- Out of Network Fee Schedules - The FUND shall adopt and amend the out of network fee schedule (“the schedule”) used from time to time. The schedule shall be based on an independent methodology, generally Medicare plus a markup (i.e., 150% of Medicare) that ensures fairness and reasonableness related to the provider type, type of procedure and geography. If adopted by the FUND such programs shall apply to all members of the FUND. Individual members may separately be exempted from the application of such programs only with the express approval of the Executive Committee and after agreeing to an appropriate rate adjustment.

28). OUT OF NETWORK MEDICARE SCHEDULE APPEAL PROCESS

Once the member appeal has been submitted, the Program Manager and the Executive Director’s Office shall initially review all OON payment appeals and shall prepare a memo summarizing the relevant facts and issues involved in the appeal.

An Out of Network benefit appeal must be filed by the claimant within 30 days from the date of receipt of the Explanation of Benefits (EOB) reflecting the 150% of Medicare for providers and 175% of Medicare for facilities.

The Program Manager will conduct a preliminary review within five (5) business days of receipt of the request for a Third-party review and notify the member and/or representing broker, the request is being forwarded to a Third-Party Review Organization solely responsible for reviewing Out of Network claims reimbursement.

The Program Manager shall then forward an eligible, complete request for external review to the Out of Network Third Party Review Organization.

The Third-Party Review Organization designated by the FUND will be required to conduct its review in an impartial, independent, and unbiased manner and in accordance with applicable law within thirty (30) business days after receipt.

If the decision of the Third-Party Review Organization responsible for the final determination is to pay the additional reimbursement at a level above the FUND approved 150% of Medicare for providers and 175% of Medicare for facilities, then the TPA is hereby authorized to issue the adjusted payment to the provider.

If the decision of the Third-Party Review Organization responsible for the final determination is to NOT pay the additional reimbursement in excess of the FUND approved 150% of Medicare for providers and 175% of Medicare for facilities, then the Program Manager will notify the member and/or representing broker within five (5) business days.

Regardless of the determination, the Third-Party Review Organization will provide on their letterhead the reason for the determination in addition to any specific data and metrics supporting that determination.

29.) NEW JERSEY PROTECTIONS FOR INVOLUNTARY, INADVERTENT AND EMERGENCY OUT OF NETWORK CLAIMS

The below information is applicable to New Jersey residents who are enrolled in the plan. In response to surprise bill concerns, the New Jersey Department of Insurance enacted the Out-Of-Network Consumer Protection, Transparency, Cost, Containment and Accountability Act (Act) (N.J.S.A. 26:2SS-1). This Act provides certain consumer protections for surprise bills for out-of-network health care services. Your employer has voluntarily elected that the plan participates in this Act.

The Act provides protections for the two types of claims specified below:

1. Involuntary and inadvertent out-of-network services

You are protected from balance bills by a New Jersey 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.) located in New Jersey and, for any reason, in-network health care services are unavailable at that facility (an “inadvertent out-of-network service”). This includes laboratory testing (e.g., imaging, X-rays, blood tests and anesthesia).

Except as provided below, you should not be balance billed by an out-of-network health care professional or facility, for any amount in excess of what your deductible, copayment, or coinsurance amounts (also known as “cost-sharing”) would be if you received the same service in-network. If you receive a bill for any other amount, please contact us at the number on your Identification Card and we will help address it. You may also file a complaint with the Department of Banking and Insurance by visiting <https://www.state.nj.us/dobi/consumer.htm>.

If you receive a bill for an amount above of your cost-sharing responsibilities for an inadvertent out-of-network service, Aetna and the out-of-network health care professional or facility may negotiate and settle on an amount for the service. If that negotiated amount exceeds what was shown on your initial Explanation of Benefits (EOB), your out-of-pocket cost-sharing responsibility may increase. If this occurs, you will be provided a second EOB showing your total cost-sharing responsibility.

If an agreement cannot be reached, Aetna or the out-of-network health care professional or facility may initiate binding arbitration to determine the amount to be paid for the inadvertent out-of-network service. The amount awarded by the arbitrator may exceed what Aetna has already paid to the out-of-network health care professional or facility; however, any additional payment for the arbitration award **will not** increase your cost-sharing responsibility above the amount indicated on your second EOB. In addition, if an arbitration takes place, you will also receive a final EOB showing the total allowed charge/amount for the service(s).

2. Medically necessary treatment on an emergency or urgent basis

You have additional protections from balance bills by any New Jersey facility involving medically necessary treatment on an emergency or urgent basis. Under this heading, “emergency and urgent

care 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, which includes: (1) medical and psychiatric care, which shall be available 24 hours a day, seven days a week; (2) coverage for trauma services at any designated Level I or II trauma center as medically necessary (such coverage shall continue at least until, in the judgment of the attending physician, you are medically stable, no longer require critical care, and can be safely transferred to another facility; (3) coverage for out-of-service area medical care when medically necessary for urgent or emergency conditions where you cannot reasonably access in-network services; (4) prehospital care and hospital services regardless of location when medically necessary for injury or emergency illness; and (5) upon a your arrival in a hospital, coverage of a medical screening examination, as required by the Federal Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd, and as specified in N.J.A.C. 8:43G-12.

Except as discussed below, you should not be billed by any facility, for any amount in excess of any deductible, copayment, or coinsurance amounts (also known as “cost-sharing”) would be if you received the same service in-network. If you receive a bill for any other amount, please contact us at the number on your Identification Card and we will help address it. You may also file a complaint with the Department of Banking and Insurance by visiting <http://www.state.nj.us/dobi/consumer.htm>.

If you receive a bill from an out-of-network health care professional or facility for an amount above of your cost-sharing responsibilities involving medically necessary treatment on an emergency or urgent basis, Aetna and the out-of-network health care professional or facility may negotiate and settle on an amount for the service. If that negotiated amount exceeds what was shown on your initial Explanation of Benefits (EOB), your out-of-pocket cost-sharing responsibility may increase. If this occurs, you will be provided a second EOB showing your total cost-sharing responsibility.

If an agreement cannot be reached, Aetna or the out-of-network health care professional or facility initiate binding arbitration to determine the amount to be paid for the medically necessary treatment on an emergency or urgent basis. The amount awarded by the arbitrator may exceed what Aetna has already paid to the out-of-network health care professional or facility; however, any additional payment for the arbitration award **will not** increase your cost-sharing responsibility above the amount indicated on your second EOB. In addition, if an arbitration takes place, you will also receive a final EOB showing the total allowed charge/amount for the service(s).

ADOPTED: MARCH 18, 2026

BY: _____
CHAIRPERSON

ATTEST: _____
SECRETARY