REVISED RESOLUTION NO. 30-25

SCHOOLS HEALTH INSURANCE FUND
RISK MANAGEMENT PLAN FOR FUND
YEAR: 2025-2026

Effective: 7/30/2025

Adopted: 7/30/2025

REVISED: February 25, 2026

WHEREAS, Article III, Section C (vii) of the Fund Bylaws requires that the Board of Trustees establish the Risk Management Plan for the Fund; and

WHEREAS, The policies established in the Risk Management Plan shall be implemented by the Executive Director, Program Manager, and all fund contractors and subcontractors;

NOW, THEREFORE, BE IT RESOLVED that **The RISK MANAGEMENT PLAN** for the Schools Health Insurance Fund (the "FUND"), for the year beginning July 1, 2025 and ending on June 30, 2026 shall be as set forth below:

1.) COVERAGE OFFERED

- Medical

  The medical plans offered by the FUND include standard "educators plan", "preferred provider organization", "traditional", "point of services", "tiered", and "health maintenance organization" plan designs and such other plan designs as approved by the Board of Trustees and the Commissioner of the Department of Banking and Insurance. These plans have both in network and out of network benefits and customized to the needs and specifications of the members. The FUND also offers "low-cost plans" to allow members options to comply with contribution requirements under Chapter 78. Included as options are a health savings account, a core PPO program, and a buy up PPO program, an HMO program and a Consumer Directed Health Plan and those plans required under chapter 44.

- 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 coordinate with the low-cost medical plans.

- Vision

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

2.) LIMITS OF COVERAGE

Limits of coverage vary by member and plan design.

3.) CEDED RISK, MEMBERSHIP IN MRHIF, AND RETAINED RISK

The FUND provides coverage on a self-insured basis and secures excess insurance and/or reinsurance to cap the specific (i.e. per enrolled 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 and/or reinsurance that is filed with the Department of Banking and Insurance in accordance with the applicable regulations.

- Medical and Prescription Specific Claims Coverage

The FUND self-insures for the first $575,000 of any medical and/or prescription drug claim per person per agreement year and obtains reinsurance through its membership in the MRHIF for claims more than its Self-Insured Retention 'SIR" to an unlimited maximum per contract year. Both FUND and MRHIF claims are calculated as incurred in 12 months and paid in 24 months.

- Medical and Prescription Aggregate Claims Coverage

The FUND does not purchase aggregate reinsurance for medical and prescription coverage.

- Dental Specific and Aggregate Claims Coverage

The FUND does not purchase either aggregate or specific coverage for dental claims.

4.) ASSUMPTIONS AND METHODOLOGY TO CALCULATE CLAIM RESERVES.

The FUND complies with statutory accounting standards and establishes reserves on the probable total claim costs at the conclusion of the FUND Year. Each month, the accrual in the general ledger for claim reserves, including IBNR, is adjusted by the executive director's office based on earned underwriting income and the number of months since the inception of the FUND Year. This accrual is periodically adjusted, but not less frequently than annually, in accordance with the actuary's certifications.

5.) METHODS OF ASSESSING CONTRIBUTIONS TO MEMBERS

At least one month before the end of the FUND Year, the FUND adopts a budget for the upcoming year based on the most recent census, the claims experience for the current FUND Year and other applicable accounting and actuarial factors.

Per employee 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 process.

Contributions by member include an actuarial factor to assure that individual entity rates reflect the risk profile of the member. The FUND implements individual entity loss ratio adjustments of up to +/- 2.5% relative to the average required renewal for medical and prescription. Such loss ratio adjustments will be applied after a group has at least 2 years of claims experience in the Fund.

The FUND may also adopt rate changes during the to reflect changes in plan design, participation in lines of coverage, utilization management, or a budget amendment. Additionally, if a member terminates a line of coverage but continues membership for other lines of coverage, the rates for the other lines of coverage may be adjusted and the member shall not be eligible for membership in the dropped line of coverage for a three (3) year period.

6.) MONTHLY BILLING OF CONTRIBUTIONS AND ASSESSMENTS

Rates derived under the above section are used to compute the monthly assessment for each member of the FUND members based on the updated census. Monthly billings are provided to the FUND members approximately 15 days before the beginning of the month. The billing also includes the member's updated census for verification each month by the local entity although former employees (COBRA, Conversion, and Retirees) may be billed directly by the FUND.

7.) RETROACTIVE BILLING ADJUSTMENTS

Retroactive adjustments for enrollment changes are limited to 2 months. 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.

8.) 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.

9.) MONTHLY PAYMENT DEFERRAL OPTION

Members that renew on July 1 have the option of taking a payment deferment by paying their June assessment in the subsequent month of July. Members that renew on January 1 have the option of taking a payment deferment by paying their December assessment in the subsequent month of January. Members that choose to take such deferments shall advise the FUND Executive Director's office in writing at least one month prior to taking the deferment.

10.) INITIAL RATING METHODOLOGIES

Upon application to the FUND, the actuary reviews a prospective member's benefit program to determine its projected claim cost. In this evaluation, the actuary takes into consideration:

- age/sex factor as compared to the average for the existing FUND membership.
- the plan of benefits for the prospective member; and
- loss data if available.
- fixed costs for reinsurance and expenses
- margin to protect the FUND from claims variability.

The actuary then recommends a relativity factor to either the FUND's base rates or to the rates paid by the entity. The Board of Trustees of the FUND must approve the rates recommended by the actuary before the prospective member is approved for membership in the FUND.

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.

11.) LIMITS ON GROWTH IN MEMBERSHIP

To manage potential volatility that could result from rapid growth, the FUND may

- limit growth in medical membership to 20% of the prior year's medical enrollment;
- prohibits cross subsidization of rates between new members; and
- requires new members to use all medical and Rx utilization management standards adopted by the FUND unless explicit waivers are granted in the resolution approving membership.

12.) "RUN-IN" AND "RUN OUT" CLAIMS 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 Board of Trustees, 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 Board of Trustees. The assessment shall be paid entirely within the FUND Year the member joined the FUND.

13.) ENROLLMENT AUDITS

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

14.) CLAIMS AUDIT

The FUND retains a claim auditor experienced in auditing self-insured health plans. The audit will occur upon completion of the first FUND Year after the FUND's inception and at least once every three (3) years thereafter. The FUND can conduct this audit on its own, or in a cooperative effort with other health joint insurance funds through the Municipal Reinsurance Health Insurance Fund.

15.) LOSS EXPERIENCE DATA DISTRIBUTION TO MEMBER ENTITIES

Loss experience data used by the FUND to determine loss ratio adjustments will be available no more frequently than twice per year to members at no additional cost. "Loss experience data" is defined as monthly claims and assessments for a three (3) year period including de-identified specific claims at 50% of the FUND's self-insured retention. Requests for additional claims data from FUND members will be considered based upon the availability of data, the feasibility of extracting the data, and conditioned upon the member reimbursing the FUND or its vendors for data extraction and formatting costs.

16.) CLAIMS AGENT NETWORK REPORTING

Medical claims agents shall formally report to the FUND at least annually on network contract changes and the potential fiscal impact of such changes on the prospective charges and fees. (A medical claim agent is also referred to as the health plan or third party administrator.)

17.) TERMINATION OF MEMBERSHIP

Former members of the FUND cannot rejoin the FUND for a period of three (3) years after the date of the termination of their membership in the FUND.

18.) OPEN ENROLLMENT PROCEDURES

All members have an open enrollment period no later than the first month of their joining the FUND. Participating employees also have an annual open enrollment with changes effective at the beginning of the FUND Year.

19.) 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 SEHBP. 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 or in the event of nonpayment of applicable charges.

20.) DISCLOSURE OF BENEFIT LIMITS

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

21.) 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.

22.) RETIREES

The FUND administers coverage for eligible retirees and uses the rates established by the FUND actuary. 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 or in the event of nonpayment of applicable charges.

23.) 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 sixty (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)."

24.) PLAN DOCUMENT

The FUND prepares a plan document and benefit plan booklets for each member local unit (or each employee group within a member local unit as the case may be), and an employee benefit booklet that 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 coverage can change.
- When coverage ends.
- COBRA provisions.
- Conversion privileges; and
- Enrollment forms and instructions.

B.) Benefits

- Definitions.
- Description of each benefit, inclusive of.

  Eligible and covered services and supplies; Deductibles and co-payments; and Examples as needed.
  Exclusions.
  Retiree coverage, before age 65 or after (if any).

C.) Claims Procedures

- Submission of claim. In accordance with plan document.
- Proof of loss. In accordance with plan document
- Appeal procedures. Shall be in accordance with applicable governing law. See also Plan Document and FUND Risk Management Plan and Bylaws

D.) Cost Containment Programs – In accordance with plan document.

- Pre-admission.
- Second surgical opinion.
- Case Management.
- Other cost containment and/or population health programs.
- Application and level of employee penalties.

25.) SURPLUS RETENTION AND PROCEDURES FOR THE CLOSURE OF FUND YEARS

The Board of Trustees shall, at least annually, review surplus retention objectives and status. The FUND has determined that maintaining and retaining a surplus equal to two and a half (2.5) months of the current year estimated claim expenses is its benchmark for a dividend declaration.

Approximately six months after the end of a FUND fiscal or incurred 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.

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 is added to its existing balance in the Closed FUND Year/Contingency Account.
- Any member that has withdrawn from the FUND shall receive its remaining share of the Closed FUND Year/Contingency Account on the following schedule:
    - 3rd year after withdrawal - 25% of balance
    - 4th year after withdrawal - 25% of balance
    - 5th year after withdrawal - 25% of balance
    - 6th year after withdrawal - Remaining balance

23. MAXIMUM APPROVAL AMOUNT FOR CERTIFYING & APPROVING OFFICER

The FUND Treasurer shall act as "certifying and approval officer" and thus may issue checks or initiate wire transfers in payment of medical, pharmacy, and dental claims, as submitted by the third party administrator responsible for handling the FUND's claims, as necessary in order to fulfill the FUND's claim funding obligations under the applicable service provider contract between the FUND and the third party administrator. The certifying and approving officer shall prepare a report of all claims approved by him or her in aggregate by year and line of coverage. This report shall be submitted to the Board of Trustees of the FUND at their next scheduled meeting. The Board of Trustees shall review and approve the actions of the certifying and approving officer. In the event claims approved and paid by the certifying and approving officer is not approved by the Board of Trustees, they shall direct appropriate action to be taken.

26.) CLAIM APPEAL COMMITTEE AND INDEPENDENT REVIEW ORGANIZATIONS

- The TPA shall initially review all appeals and shall prepare a memo summarizing the relevant facts and issues involved in the appeal.
    - The TPA shall provide the Program Manager, Executive Director and the FUND Attorney with a copy of the memo, which has been prepared concerning the appeal.
    - The TPA, Program Manager, Executive Director and FUND Attorney shall confer concerning the merits of an appeal and they shall render a decision concerning the appeal provided that the appeal is
        - (a) In an amount not greater than $5,000.00 and/or
        - (b) Has been reviewed and recommended for approval by an independent, third party medical review consultant.
- If the decision of the TPA, Program Manager, Executive Director and FUND Attorney is to pay the claim, then the TPA is hereby authorized to issue the necessary check in payment of the claim.
- The Board of Trustees of the FUND shall formally confirm the decision of the TPA, Program Manager, Executive Director and FUND Attorney to pay the claim and ratify the payment issued pursuant to that decision at the next meeting of the Board of Trustees.
    - If the decision of the TPA, Program Manager, Executive Director and FUND Attorney is to deny the 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 the 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 by the IRO if (i) the claimant is not 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 or (iii) the claimant is not eligible due to the benefit/coverage being an excluded benefit or not included as a covered benefit. 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 of IRO assignment 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 contract 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://wwww.state.nj.us/dobi/consumer.htm e- mail address: ombudsman@dobi.state.nj.us/

27.) 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 and is 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 TRUSTEES and after agreeing to an appropriate rate adjustment.

28.) IDENTIFICATION AND CORRECTIVE ACTION FOR OUTLIER PROVIDERS

A "medical claims outlier identifier" refers to a process or system that identifies claims or patient encounters that deviate significantly from the norm or average, often due to unusually high-costs or resource utilization, requiring further investigation.

Such processes and systems are needed to assist with:

- Fraud Detection: Outliers can signal potentially fraudulent activity, such as inflated charges or improper coding.
- Error Detection: They can highlight coding errors, billing mistakes, or data entry issues.

- Process Improvement: Identifying outliers can help healthcare organizations understand and address inefficiencies in their billing or coding processes.
- Reimbursement Accuracy: Outliers can impact the accuracy of reimbursements, leading to overpayments or underpayments.

Once identified, outliers may be further investigated using accepted industry practices to identify aberrant claims submissions based on, but not limited to the following:

- Scheduled review of the top provider submissions by total claims dollars
- Scheduled review of providers identified by the medical TPA as aberrant claim submission practices

While most such investigative processes are completed by the TPA, investigations may also be initiated by other FUND vendors including claims, financial, and reinsurance auditors.

If, based on a preponderance of empirical evidence, and as recommended by the Fund's professionals, certain out of network providers may be deemed ineligible for any level of reimbursement with the Fund by and through the Fund's TPA.

- Such evidence shall be of a nature that indicates potentially fraudulent behavior, unscrupulous or aberrant billing practices, issues impacting patient safety or quality or other issues that suggest said provider(s) may cause quality or financial harm to the Fund.
- Such matters shall be evaluated by the Fund's executive committee and in consultation with the Fund's professionals, including counsel or separate outside clinical advisory, to ensure the most thorough determinations are being made.
- If after a thorough review has taken place and the executive committee deems removal is warranted, the Fund shall take measures to have said provider(s) deemed ineligible for any level of reimbursement with the Fund by and through the Fund's TPA. The Fund shall also ensure proper notice is provided to covered plan members that may be using said providers so they are aware that benefits shall be ineligible for payment through the Fund at a certain date.

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: 7/30/2025

REVISED: February 25, 2026

BY: Joseph M Collins
CHAIRPERSON

ATTEST:
SECRETARY