NEW JERSEY OUT-OF-NETWORK CONSUMER PROTECTION, TRANSPARENCY, COST CONTAINMENT AND ACCOUNTABILITY ACT.

Disclosures to consumers, Cigna enrollees and prospective enrollees 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.

If you're covered under a plan through Cigna, you should refer to your group policy certificate or evidence of coverage, 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 provider or facility is in- or out-of-network, please contact us at the toll-free number on your Cigna ID card, or visit your coverage information page at **myCigna.com**.

IF YOU ARE COVERED UNDER A POLICY ISSUED IN NEW JERSEY

Your policy covers:	What this means:	How am I protected by NJ law?
Medically necessary treatment on an emergency or urgent basis by out-of-network health care providers or facilities	**Emergency** You are covered for out-of-network treatment for emergency conditions. The law defines these as *a 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.*	Except as outlined below, you should not be billed by an out-of-network health care provider or facility for more than any deductible, copay, or coinsurance amounts (also known as "cost-sharing") that apply to the same services you get when you stay in-network. If you get 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. Your carrier and the out-of-network health care provider/facility may negotiate and settle on an amount that they agree to accept 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.

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Your policy covers:	What this means:	How am I protected by NJ law?
	This includes any further medical examination and such treatment as may be required to stabilize the medical condition. This also includes situations where there is inadequate time for a safe transfer of a pregnant woman to another hospital before delivery, or where such a transfer may pose a threat to the health or safety of the mother 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 provider within 24 hours.	If an agreement cannot be reached, your carrier or the out-of-network health care provider/facility may choose to enter into binding arbitration to determine the amount to be paid for the medical services. The amount awarded by the arbitrator may exceed what the carrier has already paid to the out-of-network health care provider/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 provider/facility before any arbitration. If arbitration is conducted, you will also get a final Explanation of Benefits that will show the total allowed charge/amount for the service(s). PLEASE NOTE THAT THESE OUT-OF-NETWORK NEGOTIATION AND ARBITRATION PROVISIONS ARE ONLY APPLICABLE TO SERVICES PROVIDED BY A PROVIDER THAT IS LICENSED OR CERTIFIED IN NEW JERSEY.
Inadvertent out-of network services (sometimes called "surprise bills")	You are covered for treatment by an out-of-network health care provider for covered services when you use an in-network health care facility (e.g., hospital, ambulatory surgery center, etc.) if in-network health care services are unavailable or provided by an out-of-network health care provider in that in-network facility. This includes laboratory testing ordered by an in-network health care provider and performed by an out-of-network bioanalytical laboratory (e.g., imaging, x-rays, blood tests and anesthesia).	Except as outlined below, you should not be billed by an out-of-network health care provider or facility for more than any deductible, copay, or coinsurance amounts (also known as "cost-sharing") that apply to the same services you get when you stay in-network. If you get 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 Your carrier and the out-of-network health care provider/facility may negotiate and settle on an amount that they agree to accept 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.

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Your policy covers:	What this means:	How am I protected by NJ law?
		If an agreement cannot be reached, your carrier or the out-of-network health care provider/facility may choose 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 provider/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 provider/facility before any arbitration. If arbitration is conducted, you will also get a final Explanation of Benefits that will show the total allowed charge/amount for the service(s). PLEASE NOTE THAT THESE OUT-OF-NETWORK NEGOTIATION AND ARBITRATION PROVISIONS ARE ONLY APPLICABLE TO SERVICES PROVIDED BY A PROVIDER THAT IS LICENSED OR CERTIFIED IN NEW JERSEY.
Treatment from out-of-network health care providers/ facilities if in-network health care providers/ facilities are unavailable	Plans are required to have adequate networks to provide you with access to providers/ facilities within certain time/ distance requirements so you can get medically necessary treatment of all illnesses or injuries covered by your plan.	You can ask for treatment from an out-of-network health care provider/facility when an in-network health care provider/facility is unavailable through an appeal, often called an "in-plan exception." Please see the Department of Banking and Insurance's guide at nj.gov/dobi/appeal/.

ADDITIONALLY, IF YOUR NEW JERSEY POLICY PROVIDES 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 provider/facility when you knowingly, voluntarily and specifically select an out-of-network health care provider/ facility, even if you have the opportunity to be serviced by an in-network health care provider/ facility. We will cover voluntary out-of-network services as described in your group policy certificate or evidence of coverage, and Summary of Benefits and Coverages.	Carriers must provide ready access to information about how to determine when a health care provider/ facility is in-network. Please contact us if you have any questions about the status of a particular provider/facility. Additionally, health care providers/facilities must share with you, in writing or on a website, the plans in which they participate as in-network providers. Indications that a provider/facility "accepts" a certain health plan does not necessarily indicate in-network status. So, when seeking treatment, you can check with us or your prospective health care provider/ facility.

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ADDITIONALLY, IF YOUR NEW JERSEY POLICY PROVIDES OUT-OF-NETWORK COVERAGE

Your policy covers:	What this means:	How am I protected by NJ law?
	Please know that the ALLOWED CHARGE/AMOUNT (discussed above) is not the same as the amount billed by your out-of-network health care provider/facility, and is usually less. WE CALCULATE THE ALLOWED CHARGE/AMOUNT AS DESCRIBED IN YOUR GROUP POLICY CERTIFICATE OR EVIDENCE OF COVERAGE. You will be RESPONSIBLE FOR PAYING: 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 provider/facility bills for the services (commonly referred to as the "balance bill").	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 provider/facility. YOU CAN VISIT THIS WEBSITE, www.fairhealthconsumer.org/, AND FOLLOW THE PROMPTS TO VIEW COST ESTIMATES FOR SPECIFIC SERVICES IN A GEOGRAPHIC AREA. Additionally, you can contact us at the toll-free number on your ID card to get information on the allowed charge/amounts for specific procedures if you can provide a current procedural terminology (CPT) code. If you do not have a CPT code, you can get an estimate of your costs by providing information about the procedures you are seeking an estimate for and your coverage policy to our Customer Service Advocate. PLEASE NOTE THAT ANY ESTIMATES OR EXAMPLES FOR OUT-OF-NETWORK COSTS DO NOT TAKE INTO ACCOUNT THE AMOUNTS THAT MAY HAVE ALREADY BEEN PAID FOR COST-SHARING THAT ACCUMULATES TOWARD OUT-OF-POCKET MAXIMUMS.

ADDITIONALLY, IF YOUR NEW JERSEY POLICY PROVIDES ONLY IN-NETWORK COVERAGE

Our 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 provider/facility when you knowingly, voluntarily and specifically select an out-of-network provider/facility for treatment when you have the opportunity to be serviced by an in-network health care provider/facility.	As discussed above, you can ask for treatment from an out-of-network health care provider/facility when an in-network health care provider/facility is unavailable, by asking for an in-plan.

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