Three Penn Plaza East
Newark, NJ 07105-2200
HorizonBlue.com

June 25, 2019

Group Benefits Administrator
SUSSEX WANTAGE BOE - ACTIVES
27 Bank St
Sussex, NJ 07461

Re: Annual WHCRA Notification for 085107

Dear Group Benefits Administrator:

The Women's Health and Cancer Rights Act of 1998 requires that an annual notification of certain health coverage for breast reconstructive surgery related to mastectomies be distributed to all plan participants.

The enclosed flyer may be used to meet the annual notification requirement for 2019. This flyer may be distributed to your employees by mail or email, or included in an employee newsletter.

This notice is also available online at **HorizonBlue.com/whcra**.

If you have any questions about this notification, please contact your Horizon Blue Cross Blue Shield of New Jersey Account Manager.

Sincerely,

Kristen Jarosz
Director
Contract Administration

Enclosure

J202325 22592 003i009

Women's Health and Cancer Rights Act of 1998

Under federal legislation, annual notification of this benefit is required to all members.

In 1998, the federal government enacted a law that mandates certain health coverage for breast reconstructive surgery in any health program that provides medical and surgical benefits for mastectomies. This law is known as the Women's Health and Cancer Rights Act.

If a covered person is receiving benefits in connection with a mastectomy and elects to have breast reconstruction along with that mastectomy, the policy must provide in a manner determined in consultation with the attending physician and the patient, coverage for the following:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications at all stages of the mastectomy, including lymphedema.

These benefits will be provided subject to deductibles and coinsurance to the same extent as for any other illness under your coverage.

All other features and benefits of this program remain the same and are not impacted by this annual notification.

Disclosures to Covered Persons 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 his or her out-of-network benefits. This summary does not alter your coverage in any way.

The covered person should refer to his or her individual policy, group policy, Certificate or Evidence of Coverage (if employer group plan), or Summary of Benefits and Coverage for more information about his or her out-of-network benefits and about coverage and costs for in-network treatment.

For additional information, including whether a health care professional or facility is in-network or out-of-network, examples of out-of-network costs and estimates for specific services, please contact us at:

1-800-355-BLUE (2583)	Monday, Tuesday, Wednesday and Friday, between 8 a.m. and 6 p.m., Eastern Time (ET), and Thursday, between 9 a.m. and 6 p.m., ET
1-833-876-3825	Monday, Tuesday, Wednesday and Friday, between 6 p.m. and 12 a.m., ET, and on Thursday, between 6 p.m. and 1 a.m., ET.
Or visit our website at:	**HorizonBlue.com/oon**

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 Professionals/ Facilities	Emergency – You are covered for out-of-network treatment for a medical 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. This includes any further medical examination and such treatment as may be required to stabilize the medical condition. This also includes if there is inadequate time to affect a safe transfer of a pregnant woman to another hospital before delivery or such transfer may pose a threat to the health or safety of the woman 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 professional within 24 hours.	Except as discussed below, you should not be billed by an out-of-network health care professional or facility, for any amount in excess of any deductible, copayment, or coinsurance amounts (also known as "cost-sharing") applicable to the same services when received in-network. If you receive 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 professional/facility may negotiate and settle on an amount that is ultimately paid 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. If an agreement cannot be reached, your carrier or the out-of-network health care professional/facility may seek 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 professional/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 professional/facility before any arbitration. If arbitration is conducted, you will also receive a final Explanation of Benefits that will show the total allowed charge/amount for the service(s).
Inadvertent out-of-network services	You are covered for treatment by an 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.) and, for any reason, in-network health care services are unavailable or provided by an out-of-network health care professional in that in-network facility. This includes laboratory testing ordered by an in-network health care professional and performed by an out-of-network bio-analytical laboratory (e.g., imaging, X-rays, blood tests and anesthesia).	Except as provided below, you should not be billed by an out-of-network health care professional or facility, for any amount in excess of any deductible, copayment, or coinsurance amounts (also known as "cost-sharing") applicable to the same services when received in-network. If you receive 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 professional/facility may negotiate and settle on an amount that is ultimately paid for the inadvertent out-of-network services. If that negotiated amount exceeds what was indicated

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Treatment from out-of-network health care professionals/ facilities if in-network health care professionals/facilities are unavailable.	Plans are required to have adequate networks to provide you with access to professionals/facilities within certain time/distance requirements so you can obtain medically necessary treatment of all illnesses or injuries covered by your plan.	You can request treatment from an out-of-network health care professional/facility when an in-network health care professional/facility is unavailable through an appeal, often called a request for an "in-plan exception." Please see the Department of Banking and Insurance's guide at: **https://nj.gov/dobi/appeal/**.

Your 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 professional/facility when you knowingly, voluntarily and specifically select an out-of-network health care professional/facility for treatment when you have the opportunity to be serviced by an in-network health care professional/facility.	As discussed above, you can request treatment from an out-of-network health care professional/facility when an in-network health care professional/facility is unavailable through an appeal, called a request for "in-plan exception."

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Voluntary out-of-network services	You are covered for treatment by an out-of-network health care professional/facility when you knowingly, voluntarily and specifically select an out-of-network health care professional/facility, even if you have the opportunity to be serviced by an in-network health care professional/facility. We will cover voluntary out-of-network services as follows: Please see the relevant Covered Services and Supplies Out-of-Network Allowance and Schedule of Covered Services and Supplies in your Policy. Please be advised that the ALLOWED CHARGE/ AMOUNT (discussed above) is not the same as the amount billed by your Out-of-Network Health Care Professional/Facility, and is usually less. WE CALCULATE THE ALLOWED CHARGE/AMOUNT AS FOLLOWS: Horizon BCBSNJ uses many sources to calculate its reimbursement rate for out-of-network services, including industry resources provided by entities such as FAIR Health, the Centers for Medicare & Medicaid Services (CMS), and	Carriers must provide ready access to information about how to determine when a health care professional/facility is in network. Please contact us if you have any questions about the status of a particular professional/facility. Additionally, health care professionals/facilities must disclose to you, in writing or on a website, the plans in which they participate as in-network providers. Note, indications that a professional/facility "accepts" a certain health plan does not necessarily indicate in-network status. So, when seeking treatment, you can check with both us and your prospective health care professional/facility. 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 professional/facility. YOU CAN CONTACT US VIA THE METHODS ABOVE TO OBTAIN MORE INFORMATION REGARDING THE ALLOWED CHARGE/AMOUNTS FOR SPECIFIC SERVICES IF YOU CAN PROVIDE A CURRENT PROCEDURAL TERMINOLOGY

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	other databases. Please review your coverage documents and reference **HorizonBlue.com/ooncalculator**. You will be RESPONSIBLE FOR PAYMENT OF: 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 professional/facility bills for the services (commonly referred to as the "balance bill").	(CPT) CODE. If you do not have a CPT code, you can estimate your costs by visiting **HorizonBlue.com/ooncalculator**. You can also visit our website above for examples of the average costs (allowed charge/amount, billed amount, consumer responsibility without cost-sharing under plan) for 10 more frequently billed out-of-network services.