Genesis Laboratory Management, LLC
The Laboratory of Choice

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The New Jersey Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act
Disclosure Form

Dear Patient:

Genesis Laboratory Management ("Genesis") is a licensed and accredited provider of clinical laboratory services ("Services"), which participates in the Medicare Integrity Program. Genesis provides Services to health care providers ("Providers") upon request. Those Services provide guidance to your Provider with respect to your health care and may affect your future medical treatment. Because the Services you may receive might or might not be are affected by the law, which Governor Murphy signed on June 1, 2018, called the Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act, codified as N.J.S.A. 26:2SS-1 (the "Law"), Genesis is required to make this and other certain disclosures to you.

The Law is only applicable to those health insurance carriers that are governed by the New Jersey State Department of Banking and Insurance, which is approximately 30% of the health insurance market, as well as self-funded federal and "ERISA" plans that opted-in, to protect that group of patients from surprise out-of-network medical bills ("Covered Patients"). Therefore, in advance of having a laboratory test performed, and to the extent your Provider can anticipate the exact clinical laboratory test that is going to be performed, you have the right to contact your health insurance carrier in advance of your medical procedure to determine if (a) you are a Covered Patient, and (b) if the Service is a covered benefit for which you are a Covered Patient. You have rights under the Law, which requires that your health insurance carrier must provide you with:

1. A clear and understandable description of the health insurance plan's out-of-network health care benefits, including the methodology used by the health insurance carrier to determine the allowed amount for out-of-network services;
2. The allowed amount the plan provided by your health insurance carrier will reimburse under that methodology;
3. Examples of anticipated out-of-pocket costs for frequently billed out-of-network services;
4. Information that reasonably permits a Covered Person or prospective Covered Person to calculate the anticipated out-of-pocket cost for out-of-network services;
5. Information in response to a Covered Person's request, concerning whether a Provider is an in-network provider; and
6. Where patients receive emergency services at an out-of-network health care facility, or inadvertently receive covered services from an out-of-network professional at a health care facility (for example, where laboratory testing ordered by an in-network facility is performed by an out-of-network laboratory), the health insurance carrier must ensure that the patient incurs no greater out-of-pocket costs than he or she would have incurred with an in-network provider for covered services.

So, if you are a Covered Person and will receive Services provided by Genesis at a health care facility or receive medically necessary services at an in-network or out-of-network health care facility on an emergency or urgent basis, then your health insurance carrier must ensure that you incur no greater out-of-pocket costs than you would have incurred with an in-network provider for Covered Services, and Genesis shall not bill you in excess of any deductible, copayment, or coinsurance amount.

In summary, Genesis may or may not be in-network with your health insurance carrier. You are welcome to contact our billing department at 732-389-8400, with any questions you may have. Regardless, if Genesis is out-of-network with your health insurance carrier, you will not incur no greater out-of-pocket costs than you would have incurred had services been provided by an in-network provider of the Covered Services.

I have read, been given the opportunity to ask questions and I agree that should services be provided on an out-of-network basis by Genesis, it has been disclosed to me that I will incur no greater out-of-pocket costs than I would have incurred had services been provided by an in-network provider of the Covered Services.

Patient Name: _____ Witnessed by: _____
(Printed or Typed) (Printed or Typed)

_____ _____
(Signature) (Signature)

Dated: _____

PLEASE SIGN TWO COPIES OF THIS FORM

(ONE COPY TO CHART AND ONE COPY TO GENESIS)