Human Resources
New Jersey Department of Military and Veterans Affairs
101 Eggert Crossing Road ▪ PO Box 340 ▪ Trenton, NJ 08625-0340

State Health Benefits Program-SHBP

Health Benefits
Eligibility for Active Group coverage is determined by the State Health Benefits Program (SHBP). All applications to enroll, change coverage, terminate, etc. must go through Human Resources.

Full-Time State Employees

- To be eligible, you must work full-time for the State of New Jersey or be an appointed or an elected officer of the State (this includes employees of a State agency or authority and employees of a State college or university). You must work at least 35 hours per week or more to be considered full-time

Part-time and Intermittent Employees

- Certain part-time and intermittent employees are eligible for coverage. See the fact sheets on http://www.state.nj.us/treasury/pensions/hb-active-shbp.shtml for more information.

Here are a listing of plans in which you can choose from for medical health benefits. For more information on individual plans to make your choice, go to http://www.state.nj.us/treasury/pensions/hb-sbc-state-active.shtml

	PPO Plans	HMO Plan	Tiered Plan	High Deductible Health Plans
Aetna Plans	▪ Aetna Freedom 15 ▪ Aetna Freedom 1525 ▪ Aetna Freedom 2030 ▪ Aetna Freedom 2035	▪ Aetna HMO	▪ Aetna Liberty	▪ Aetna Value HD4000 ▪ Aetna Value-HD 1500
Horizon Plan	▪ NJ Direct 15 ▪ NJ Direct 1525 ▪ NJ Direct 2030 ▪ NJ Direct 2035	▪ Horizon HMO	▪ OMNIA Health	▪ NJ Direct HD4000 ▪ NJ Direct 1500

State Active Prescription Plans	
▪ State Active Prescription Plan 15 ▪ State Active Prescription Plan 1525	▪ State Active Prescription Plan 2030 ▪ State Active Prescription Plan 2035

To find your estimated Health Benefit Contribution, use the Percentage of Premium Calculator by going to the following link:
http://www.state.nj.us/treasury/pensions/hb-percentage18-biweekly.shtml

HA-0895-0717

STATE ACTIVE GROUP
MEDICAL PLAN DESIGN - PLAN YEAR 2018
AETNA AND HORIZON PLANS - MEDICAL COST SHARING

	Aetna Freedom15	Aetna Freedom1525	Aetna Freedom2030	Aetna Freedom2035	Aetna HMO	Aetna Liberty		Aetna Value HD4000*	Aetna Value HD1500*
	NJ DIRECT15	NJ DIRECT1525	NJ DIRECT2030	NJ DIRECT2035	Horizon HMO[1]	Horizon OMNIA		NJ DIRECT HD4000*	NJ DIRECT HD1500*
Medical Cost Sharing						TIER 1	TIER 2		
Primary Care Copayment	$15	$15	$20	$20	$15	$5	$20		
Specialist Care Copayment	$15	$25	$30 adult / $20 child**	$35	$15	$15	$30		
Emergency Room Copayment	$100	$100	$125	$300	$100	$100	$100		
In-Network Deductible				$200[6]	$100[2]	None	$1,500[7]	$4,000[7]	$1,500[7]
In-Network Coinsurance	10%[2]	10%[2]	10%[2]	20%[6] after deductible		None	20%	20% after deductible	20% after deductible
In-Network Coinsurance Maximum (Individual/Family)	$400 / $1,000	$400 / $1,000	$800 / $2,000	$2,000 / $5,000		None	None	$1,000 / $2,000	$1,000 / $2,000
In-Network Out-of-Pocket Maximum (Individual/Family)	$5,880 / $11,760	$5,880 / $11,760	$5,880 / $11,760	$5,880 / $11,760	$5,880 / $11,760	$2,500[7]	$4,500[7]	$5,000 / $10,000	$2,500 / $5,000
Out-of-Network Deductible (Individual/Family)	$100 / $250	$100 / $250	$200 / $500	$800 / $2,000				See In-Network Deductible[3]	See In-Network Deductible[3]
Out-of-Network Coinsurance[4]	30%	30%	30%	40%				40%	40%
Out-of-Network Out-of-Pocket Maximum (Individual/Family)	$2,000 / $5,000	$2,000 / $5,000	$5,000 / $12,500	$6,500 / $13,000				$6,000 / $12,000	$3,500 / $7,000
Out-of-Network Inpatient Hospital Deductible	$200 / stay	$200/stay	$500/stay	$600/stay					
Employer Health Savings Account Funding[5]									$300

*** HD = High Deductible Health Plan**
**** Age 26 and under**

[1] Service areas for Horizon HMO plans are limited to New Jersey, New Castle County in Delaware, and bordering counties of Pennsylvania and New York.
[2] On select services.
[3] Out-of-Network Deductible is combined with In-Network Deductible.
[4] After Deductible.
[5] Health Savings Accounts can be used for qualified medical expenses without federal tax liability.
[6] Applies to services that do not require a copayment.
[7] Family amounts are 2 x per member amounts listed in table.

HA-0895-0717

STATE ACTIVE GROUP
MEDICAL PLAN DESIGN - PLAN YEAR 2018
AETNA AND HORIZON PLANS - PRESCRIPTION DRUG COPAYMENTS

	Aetna Freedom15	Aetna Freedom1525	Aetna Freedom2030	Aetna Freedom2035	Aetna HMO	Aetna Liberty	Aetna Value HD4000*	Aetna Value HD1500*
	NJ DIRECT15	NJ DIRECT1525	NJ DIRECT2030	NJ DIRECT2035	Horizon HMO[1]	Horizon OMNIA	NJ DIRECT HD4000*	NJ DIRECT HD1500*
Prescription Drug Copayments								
Retail: Generic Copayments	$3	$7	$3	$7[3]	$3	$7	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Retail: Brand Copayments	$10	$16	$18	$21[3]	$10	$16		
Retail: Brand w/Generic available Copayments[2]	member pays difference[2]	member pays difference[2]	member pays difference[2]	member pays difference[2, 3]	member pays difference[2]	member pays difference[2]		
Mail: Generic Copayments	$5	$18	$5	$18[3]	$5	$18		
Mail: Brand Copayments	$15	$40	$36	$52[3]	$15	$40		
Mail: Brand w/Generic available Copayments[2]	member pays difference[2]	member pays difference[2]	member pays difference[2]	member pays difference[2, 3]	member pays difference[2]	member pays difference[2]		
Prescription Drug annual Out-of-Pocket Maximum (Individual/Family)	$1,470 / $2,940	$1,470 / $2,940	$1,470 / $2,940	$1,470 / $2,940	$1,470 / $2,940	$1,470 / $2,940		

*** HD = High Deductible Health Plan**

[1] Service areas for Horizon HMO plans are limited to New Jersey, New Castle County in Delaware, and bordering counties of Pennsylvania and New York.
[2] You pay the applicable generic copayment as listed above, plus the cost difference between the brand drug and the generic drug.
[3] For maintenance prescription drugs, mail order is mandatory under the 2035 plans (Aetna Freedom2035, NJ DIRECT2035).

This publication is produced and distributed by the New Jersey Division of Pensions & Benefits — *www.nj.gov/treasury/pensions*
This is a summary and not intended to provide all information. Although every attempt at accuracy is made, it cannot be guaranteed.

Health Benefits Coverage for Part-Time Employees

Information for:
All Funds

INTRODUCTION

P.L. 2003, c. 172 (Chapter 172), provides certain part-time employees of the State of New Jersey and part-time faculty members at a New Jersey State College, State University, or certain County or Community Colleges, eligibility for enrollment in the State Health Benefits Program (SHBP) or the School Employees' Health Benefits Program (SEHBP), provided that the part-time employee is a member of a State-administered retirement system.

The part-time employee may enroll in any SHBP/SEHBP plan that is provided by the employer **(except for NJ DIRECT HD1500 and Aetna Value HD1500)** and, if provided by the employer, the Employee Prescription Drug Plan. If an eligible employee elects to enroll and purchase coverage, the employee must pay the full cost of the coverage.

The plan benefits, as well as the rules and procedures of the plans, are the same for part-time enrollees as they are for all other enrollees **except for those areas listed to follow.** If a specific topic is not outlined in this publication, please refer to the the New Jersey Division of Pensions & Benefits (NJDPB) website at: ***www.nj.gov/treasury/pensions***

ELIGIBILITY AND ENROLLMENT

Part-time Active Employee Eligibility

Eligibility for coverage is determined by the NJDPB. Enrollments, terminations, changes to contracts, etc. must be processed through your employer first, then by the NJDPB. If you have any questions concerning eligibility, you should see your employer or call the NJDPB Office of Client Services at (609) 292-7524.

To be eligible for coverage under the provisions of Chapter 172, an employee must be:

- A member of a State-administered retirement system (Public Employees' Retirement System, Teachers' Pension and Annuity Fund, the Alternate Benefit Program, or the Defined Contributions Retirement Program); **and**
- A part-time employee of the State of New Jersey, a State college or university, the Palisades Interstate Park Commission, the New Jersey Building Authority, the State Library, or the New Jersey Commerce and Economic Growth Commission; **or**
- A part-time faculty member — including part-time lecturer or adjunct faculty member — employed by a State college, State university, or a county or community college that participates in the SHBP or SEHBP.

Eligible Dependents

Your eligible dependents are:

- Your spouse, civil union partner, or eligible same-sex domestic partner.*
- Your children (including step-children, legally adopted children, foster children, and legal wards) under the age of 26.

Enrollment

You cannot be covered by the health benefits provided under Chapter 172 until you enroll in **both** a New Jersey State-administered retirement system and the SHBP or SEHBP. When you become eligible for enrollment in a retirement system, your employer will provide you with the *Part-Time Employees Group Health Benefits Application*. You must complete the application, providing all of the information requested, and submit it to your employer.

Part-time employees may select **both** a medical plan and Employee Prescription Drug Plan coverage (if provided by the employer), **or** medical plan coverage **only** (part-time employees *cannot* enroll in *only* the Employee Prescription Drug Plan).

Once you are enrolled in health benefits, **you will be billed monthly** for the cost of your selected coverage. Rate charts showing the cost of coverage are available from your employer or on the NJDPB website at: ***www.nj.gov/treasury/pensions***

**For more information see the Civil Unions and Domestic Partnerships Fact Sheet.*

If you do not enroll all eligible members of your family within 60 days of the time you or they first become eligible for coverage, you must wait until the next Open Enrollment period (for exceptions see the "Changes in Coverage" section below).

Effective Dates of Coverage

There is a **waiting period of two months following your eligibility date** before your health benefits coverage begins, provided you submit a completed *Part-Time Employees Health Benefits Program Application.* For example, if you become eligible for enrollment in the retirement system on October 1 and apply for coverage under Chapter 172, your SHBP/SEHBP coverage will be effective December 1.

For some part-time employees, retirement system enrollment may be concurrent with their date of hire; other part-time employees may not be eligible for retirement system enrollment until their 13th month of continuous employment (see your human resources representative to determine your enrollment eligibility date).

Note: If you were enrolled in health benefits as a part-time employee with your previous employer, and your coverage is still in effect on the day you begin work with your current employer (COBRA coverage excluded), your coverage begins immediately so you have no break in coverage.

Your eligible dependents' coverage is effective the same date as your coverage is effective.

Changes in Coverage

Coverage changes involving the addition of dependents are retroactive to the date of the event (marriage, civil union, eligible domestic partnership, birth, adoption, etc.) provided that the application is filed within 60 days of the event. Deletion of dependents is effective on a timely or prospective basis, depending upon receipt of the application by the Health Benefits Bureau. Covered children are automatically terminated as of the end of the year they attain age 26.

Leave of Absence

If you take an approved leave of absence, your SHBP/SEHBP coverage will remain in effect **provided that you continue to pay your billed monthly premiums.**

Workers' Compensation

If you have a Workers' Compensation award pending, or have received an award of periodic benefits under Workers' Compensation or the Second Injury Fund, you and your dependents are entitled to have continued coverage at the same level as when you were an active employee. **You must continue to pay your billed monthly premiums.**

RETIREE COVERAGE

Retiree Eligibility

Upon retirement, part-time State employees and part-time faculty members, who are enrolled in the SHBP/SEHBP under the provisions of Chapter 172, are permitted to enroll in the retired group of the SHBP/SEHBP **provided that they continue to pay the full cost of their retiree coverage.** Prescription drug coverage for retirees is provided through the Retiree Prescription Drug Plan.

Retirees should also see the NJDPB's requirement regarding enrollment in Medicare Part A and Part B coverage, as outlined in the *Summary Program Description.*

Note: The provisions of Chapter 172 do not qualify an employee for State-paid or employer-paid post-retirement health care benefits under the SHBP or SEHBP. Chapter 172 retirees are responsible for paying the full cost of retired group SHBP/SEHBP coverage.

COBRA COVERAGE

Upon termination (other than for retirement) of SHBP/SEHBP coverage provided under Chapter 172, continued coverage in the SHBP/SEHBP and the Employee Prescription Drug Plan is available under federal COBRA legislation. See the *Summary Program Description (SPD)* for more information, which is available on our website at: ***www.nj.gov/treasury/pensions***

PURCHASE OF INDIVIDUAL INSURANCE COVERAGE

Part-time State employees and part-time faculty members, who are eligible to enroll under the provisions of Chapter 172, are not eligible for other health coverage plans available under the provisions of the New Jersey Individual Health Coverage (IHC) Program.

If you are covered under the IHC and eligible for coverage under Chapter 172, you must contact the carrier regarding cancellation of your IHC benefits. You may re-enroll in the IHC during the IHC's October open enrollment period (for a January effective date). If your health benefits terminate, you are immediately eligible for coverage in the individual market.

Additional information about the IHC can be obtained from the New Jersey Individual Health Coverage Board at the Department of Banking and Insurance by calling 1-800-838-0935 or at: ***http://dobi.nj.gov/***

PLAN DESCRIPTIONS

For a summary of medical plans and benefits provided under the SHBP/SEHBP, visit the NJDPB website at: ***www.nj.gov/treasury/pensions***

This fact sheet has been produced and distributed by:

New Jersey Division of Pensions & Benefits
P.O. Box 295, Trenton, NJ 08625-0295

(609) 292-7524
For the hearing impaired: TRS 711 (609) 292-6683
www.nj.gov/treasury/pensions

HA-0891-0617

State Health Benefits Program (SHBP)

STATE ACTIVE EMPLOYEE GROUP

HEALTH BENEFITS ENROLLMENT and/or CHANGE FORM

1. EMPLOYEE INFORMATION — Last Name | First | MI

Gender | Birth Date / / | Social Security Number — — | Marital Status*

Telephone Number ( ) | Personal E-mail Address

Home Address No. and Street Name

City | State | Zip

2. EMPLOYMENT STATUS

☐ Full Time ☐ Part Time ☐ Intermittent ☐ National Guard ☐ ACA *(monthly only)*

3. REASON FOR APPLICATION *(check one)*

☐ New Enrollment ☐ Transfer
☐ Open Enrollment ☐ Loss of Coverage
☐ Adding Dependents ☐ Deleting Dependents
☐ Waiver of Coverage ☐ Other

Reason________________________________

Date of Event ________/________/________

4. TYPE and LEVEL OF COVERAGE

Level	Health	Rx
☐ Single	☐	☐
☐ Parent/Child	☐	☐
☐ Member/Spouse/Civil Union	☐	☐
☐ Member/Domestic Partner	☐	☐
☐ Family	☐	☐

I have been offered the above coverage and I elect to waive participation for myself and my eligible dependents. *

☐ I elect to waive Health Coverage ☐ I elect to waive Prescription Drug Coverage

DIVISION USE ONLY

Effective Dates
H _____ _____ _____
Rx _____ _____ _____
Event Reason: ☐

EMPLOYER CERTIFICATION
(See Instructions on reverse)

Employer Name ____________________

Payroll # ____________________
(State Biweekly)

Union Code (Rx) Only ☐☐

Location # *(State Monthly)* ☐☐☐☐☐☐☐

10/12 - month employee *(Enter "10 or 12")* ☐☐

MEMBER ACTION

☐ New Enrollment ☐ Transfer

Date Employment Began ______/______/______

☐ Return from Leave of Absence ______/______/______

Signature of Certifying Officer

Telephone # *Date Mailed*

5. HEALTH PLAN

HORIZON

☐ OMNIA Health Plan
☐ NJ DIRECT15
☐ NJ DIRECT1525
☐ NJ DIRECT2030
☐ NJ DIRECT2035
☐ Horizon HMO

AETNA

☐ Aetna Liberty Plan
☐ Aetna Freedom15
☐ Aetna Freedom1525
☐ Aetna Freedom2030
☐ Aetna Freedom2035
☐ Aetna HMO

For HMO Plans only, enter Primary Care Physician's ID # ______________________________

6. Dependent Information: List all eligible dependents and attach required proof of dependency documents*

☐ **Additional sheets attached. Any dependents not listed will be removed.**

Eligible Dependents Last Name, First Name	Social Security No.	Circle Relationship	Birth Date	Gender
	— —	Spouse / Civil Union / Domestic Partner	/ /	
	— —	Child *(Natural, Adopted, Foster, Step, Legal Ward)*	/ /	
	— —	Child *(Natural, Adopted, Foster, Step, Legal Ward)*	/ /	

***See Instructions page for detailed information and Mailing Address**

EMPLOYEE CERTIFICATION — I certify that all the information supplied on this form is true to the best of my knowledge and that it is verifiable. I understand that if I waive my right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment or if other coverage is lost and proof of loss is provided (HIPAA). I also understand that there is no guarantee of continuous participation by medical providers, either doctors or facilities, in the plans. If either my physician or medical center terminates participation in my selected plan, I must select another doctor or medical center participating in that plan to receive the "in-network" benefit. I authorize any hospital, physician, or health care provider to furnish my medical plan or its assignee with such medical information about myself or my covered dependents as the assignee may require. **Misrepresentation:** Any person that knowingly provides false or misleading information is subject to criminal and civil penalties pursuant to N.J.S.A.17:33A-6c.

7. Employee Signature:______________________________ **Date:** ______/______/______

INSTRUCTIONS FOR THE SHBP STATE ACTIVE EMPLOYEE GROUP HEALTH BENEFITS ENROLLMENT and/or CHANGE FORM

SECTION 1 – EMPLOYEE INFORMATION – Complete entire section. Indicate Marital Status as follows: **S** (Single), **M** (Married), **CU** (Civil Union), **DP** (Domestic Partner), **D** (Divorced), **W** (Widowed)

SECTION 2 – EMPLOYMENT STATUS – Check one block only

SECTION 3 – REASON FOR APPLICATION – Check one block only

- **New Enrollment** – New hire or HIPAA event
- **Transfer** – Active health benefits coverage transferring from another SHBP/SEHBP location
- **Open Enrollment** – Annually in October
- **Adding Dependents** – Must be done within 60 days of event (i.e. birth, marriage, adoption – indicate reason and date)
- **Deleting Dependents** – Removal of covered dependents (indicate reason and date)
- **Loss of Coverage** – Enrolling because of loss of other coverage (application and HIPAA certificate submitted within 60 days of the loss of other coverage)
- **Waiver of Coverage** – Waive (decline) coverage
- **Other** (indicate reason and date)
- **Reason** – indicate reason
- **Date of Event** – indicate date

To waive (decline) coverage: If you wish to waive Health and/or Prescription Drug coverage under the provisions of N.J.S.A. 52:14-17.31a, check appropriate block. **NOTE: Both Health AND Prescription Drug coverage MUST be waived to avoid paying a contribution.** If you are waiving coverage for yourself or any or all of your eligible dependents because of other group health coverage, you may enroll in the future. You must provide proof of the loss of other coverage and submit it with your application within 60 days of the loss of other coverage. Otherwise you will be required to wait until the annual Open Enrollment.

SECTION 4 – TYPE AND LEVEL OF COVERAGE – Indicate by checking the appropriate block to enroll in **Health** and/or **Rx** (Prescription Drug)

- **Single** – coverage for you only
- **Parent/Child(ren)** – coverage for you and any eligible child(ren) under age 26
- **Member/Spouse/Civil Union** – coverage for you and your eligible spouse or your Civil Union Partner
- **Member/Domestic Partner** – coverage for you and your eligible Domestic Partner
- **Family** – coverage for you, your eligible Spouse/Civil Union Partner/Domestic Partner, and child(ren) under age 26

SECTION 5 – HEALTH PLAN – Select only one plan. The Health Benefits *Summary Program Description* provides you with all available options at ***www.nj.gov/treasury/pensions/member-guidebooks.shtml*** Employees who wish to enroll in a High Deductible Health Plan (HDHP) must use the appropriate application found on our website ***www.nj.gov/treasury/pensions***

SECTION 6 – DEPENDENT INFORMATION – List all eligible dependents and attach dependent documentation proof (see attached). If proper documentation has already been provided and approved, do not resubmit. If appropriate dependent documentation proof is not provided, dependents may not be enrolled. Ensure your dependents match your level of coverage (Section 4). Your child(ren) may be covered until the end of the calendar year they turn 26. **ANY DEPENDENTS NOT LISTED WILL NOT BE COVERED**.

NOTE: Use Section 3 to delete dependents.

SECTION 7 – EMPLOYEE SIGNATURE – Read, sign, date, and attach required dependent documentation. Return the application to your employer's Human Resources office for certification.

MISREPRESENTATION: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties pursuant to N.J.S.A. 17:33A-6c.

EMPLOYER CERTIFICATION – Must be completed by the Certifying Officer. The Certifying Officer's signature confirms that:

- The employee is eligible;
- The application is legible and completed in its entirety;
- The employee's selected plans and coverage levels are appropriate;
- The dependent documentation provided is complete and correct;
- The Employer Certification section is completed in its entirety; and
- The information presented is true to the best of their knowledge.

MAIL COMPLETED APPLICATION TO: **New Jersey Division of Pensions & Benefits (NJDPB)**
P.O. Box 299
Trenton, NJ 08625-0299

HB-0840-1217

State Health Benefits Program (SHBP) • School Employees' Health Benefits Program (SEHBP)

REQUIRED DOCUMENTATION FOR DEPENDENT ELIGIBILITY AND ENROLLMENT

The State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) are required to ensure that only employees, retirees, and eligible dependents are receiving health care coverage under the Programs. The New Jersey Division of Pensions & Benefits (NJDPB) must guarantee consistent application of eligibility requirements within the plans. Employees or retirees who enroll dependents for coverage (spouses, civil union partners, domestic partners, children, disabled and/or overage children continuing coverage) MUST submit the following documentation in addition to the appropriate health benefits enrollment or change of status application. If proper documentation has already been provided and approved, do not resubmit. If appropriate dependent documentation proof is not provided, dependents may not be enrolled. **ANY DEPENDENTS NOT LISTED ON THE APPLICATION WILL NOT BE COVERED.**

DEPENDENTS	ELIGIBILITY DEFINITION	DOCUMENTATION REQUIRED
SPOUSE	A person to whom you are legally married.	A copy of the marriage certificate **and** a copy of the front page of the employee/retiree's federal tax return***** (Form 1040) from last year that includes the spouse. If filing separately, submit a copy of both spouses' tax returns that list the same address. If marriage occurred in the current calendar year, a copy of the tax return is not required. **Or**, if tax return is not available, provide a copy of a bank statement or bill (dated within 90 day of the application) that includes the names of both spouses and is received at the same address.
CIVIL UNION PARTNER	A person of the same sex with whom you have entered into a civil union.	A copy of the marriage certificate **and** a copy of the front page of the employee/retiree's federal tax return***** (Form 1040) from last year that includes the partner. If filing separately, submit a copy of both partners' tax returns that list the same address. If marriage occurred in the current calendar year, a copy of the tax return is not required. **Or**, if tax return is not available, provide a copy of a bank statement or bill (dated within 90 day of the application) that includes the names of both partners and is received at the same address.
DOMESTIC PARTNER	A person of the same sex with whom you have entered into a domestic partnership. Under P.L. 2003, c. 246, the Domestic Partnership Act, health benefits coverage is available to domestic partners of State employees, State retirees, or employees or retirees of a SHBP - or SEHBP - participating local public entity that has adopted a resolution to provide Chapter 246 health benefits.	A copy of the New Jersey certificate of domestic partnership dated prior to February 19, 2007, or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners **and** a copy of the front page of the employee/retiree's N.J. tax return***** from last year that includes the partner. If filing separately, submit a copy of both partners' NJ tax returns that list the same address. If Domestic Partnership occurred in the current calendar year, a copy of the tax return is not required. **Or**, if tax return is not available, provide a copy of a bank statement or bill (dated within 90 days of the application) that includes the names of both partners and is received at the same address.
CHILDREN	A subscriber's child until age 26, regardless of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his or her parents. This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation.	**Natural or Adopted Child** – A copy of the child's birth certificate showing the name of the employee/retiree as a parent. **Step Child** – A copy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent **and** a copy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner. **Legal Guardian, Grandchild, or Foster Child** – Copies of final court orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the employee.
DEPENDENT CHILDREN WITH DISABILITIES	If a covered child is not capable of self-support when he or she reaches age 26 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuance of coverage. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP/SEHBP; (2) the child continues to be disabled; (3) the child is unmarried or does not enter into a civil union or domestic partnership; and (4) the child remains substantially dependent on you for support and maintenance. You may be contacted periodically to verify that the child remains eligible for coverage.	Documentation for the appropriate "child" type (as noted above) **and** a copy of the front page of the employee/retiree's federal tax return***** (Form 1040) from last year that includes the child. If Social Security disability has been awarded, or is currently pending, please include this information with the documentation that is submitted. Please note that this information is only verifying the child's eligibility as a dependent. The disability status of the child is determined through a separate process.
CONTINUED COVERAGE FOR OVERAGE CHILDREN	Certain children over age 26 may be eligible for continued coverage until age 31 under the provisions of P.L. 2005, c. 375. This includes a child by blood or law who: (1) is under the age of 31; (2) is unmarried or not a partner in a civil union or domestic partnership; (3) has no dependent(s) of his or her own; (4) is a resident of New Jersey or is a student at an accredited public or private institution of higher education, with at least 15 credit hours; and (5) is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare.	Documentation for the appropriate "child" type (as noted above), **and** a copy of the front page of the child's federal tax return***** (Form 1040) from last year, and if the child resides outside of the State of New Jersey, documentation of full time student status must be submitted.

*****You may black out all financial information and all but the last four digits of any Social Security numbers on tax returns. To obtain copies of the documents listed above, contact the office of the town clerk in the city of the birth, marriage, etc., or visit these websites: ***www.vitalrec.com*** or ***www.studentclearinghouse.org***
Residents of New Jersey can obtain records from the State Bureau of Vital Statistics and Registration website: ***www.nj.gov/health/vital/index.shtml***

HA-0910-1217

State Health Benefits Program (SHBP) • School Employees Health Benefits Program (SEHBP)

ACTIVE EMPLOYEE HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

HEALTH BENEFITS ENROLLMENT and/or CHANGE FORM

1. EMPLOYEE INFORMATION — Last Name | First | MI

Gender	Birth Date	Social Security Number	Marital Status*
	/ /	— —	

Telephone Number	Personal E-mail Address
( )	

Home Address No. and Street Name

City | State | Zip

DIVISION USE ONLY

Effective Dates | Event Reason:

H ____ ____ ____ ☐

EMPLOYER CERTIFICATION

(See Instructions on reverse)

Employer Name ______________________

Payroll # ______________________

(State Biweekly)

Union Code *(Rx) Only* ☐☐

Location # ☐☐☐☐☐☐☐

10/12 - month employee ☐☐

(Enter "10 or 12")

MEMBER ACTION

☐ New Enrollment ☐ Transfer

Date Employment Began

______/______/______

☐ Return from Leave of Absence

______/______/______

Signature of Certifying Officer

Telephone # | *Date Mailed*

2. EMPLOYMENT STATUS ☐ Full Time ☐ Part Time ☐ Intermittent ☐ National Guard ☐ ACA *(monthly only)*

3. REASON FOR APPLICATION ***(check one)***

☐ New Enrollment ☐ Transfer

☐ Open Enrollment ☐ Loss of Coverage

☐ Adding Dependents ☐ Deleting Dependents

☐ Waiver of Coverage ☐ Other

Reason____

Date of Event ________/________/________

4. LEVEL OF COVERAGE

Level

☐ Single

☐ Parent/Child

☐ Member/Spouse/Civil Union

☐ Member/Domestic Partner

☐ Family

☐ **I have been offered the above coverage and I elect to waive participation for myself and my eligible dependents. ***

5. HEALTH PLAN

HORIZON

☐ NJ DIRECT HD4000*** ☐ NJ DIRECT HD1500**

AETNA

☐ Aetna Value HD4000*** ☐ Aetna Value HD1500**

6. HEALTH SAVINGS ACCOUNT (HSA)

☐ I wish to establish a HSA at this time and understand that I will be contacted to establish banking. By applying for and funding my HSA I represent that I:

1) am covered under a High Deductible Health Plan (HDHP);
2) am not covered by any other non-HDHP product;
3) am not covered in Medicare; and
4) cannot be claimed as a dependent on another person's tax return.

☐ I am not enrolling in a HSA at this time and understand that if I choose to at a later date, I must contact my health plan.

7. Dependent Information: List all eligible dependents and attach required proof of dependency documents*

☐ **Additional sheets attached. Any dependents not listed will be removed.**

Eligible Dependents Last Name, First Name	Social Security No.	Circle Relationship	Birth Date	Gender
	— —	Spouse / Civil Union / Domestic Partner	/ /	
	— —	Child (Natural, Adopted, Foster, Step, Legal Ward)	/ /	
	— —	Child (Natural, Adopted, Foster, Step, Legal Ward)	/ /	

***See Instructions page for detailed information and Mailing Address**

EMPLOYEE CERTIFICATION — I certify that all the information supplied on this form is true to the best of my knowledge and that it is verifiable. I understand that if I waive my right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment or if other coverage is lost and proof of loss is provided (HIPAA). I also understand that there is no guarantee of continuous participation by medical providers, either doctors or facilities, in the plans. If either my physician or medical center terminates participation in my selected plan, I must select another doctor or medical center participating in that plan to receive the "in-network" benefit. I authorize any hospital, physician, or health care provider to furnish my medical plan or its assignee with such medical information about myself or my covered dependents as the assignee may require. **Misrepresentation:** Any person that knowingly provides false or misleading information is subject to criminal and civil penalties pursuant to N.J.S.A.17:33A-6c.

8. Employee Signature: ____ **Date:** ______/______/______

INSTRUCTIONS FOR THE SHBP & SEHBP ACTIVE EMPLOYEE HIGH DEDUCTIBLE HEALTH PLAN HEALTH BENEFITS ENROLLMENT and/or CHANGE FORM

SECTION 1 – EMPLOYEE INFORMATION – Complete entire section. Indicate Marital Status as follows: **S** (Single), **M** (Married), **CU** (Civil Union), **DP** (Domestic Partner), **D** (Divorced), **W** (Widowed)

SECTION 2 – EMPLOYMENT STATUS – Check one block only

SECTION 3 – REASON FOR APPLICATION – Check one block only

- **New Enrollment** – New hire or HIPAA event
- **Transfer** – Active health benefits coverage transferring from another SHBP/SEHBP location
- **Open Enrollment** – Annually in October
- **Adding Dependents** – Must be done within 60 days of event (i.e. birth, marriage, adoption – indicate reason and date)
- **Deleting Dependents** – Removal of covered dependents (indicate reason and date)
- **Loss of Coverage** – Enrolling because of loss of other coverage (application and HIPAA certificate submitted within 60 days of the loss of other coverage)
- **Waiver of Coverage** – Waive (decline) coverage
- **Other** (indicate reason and date)
- **Reason** – indicate reason
- **Date of Event** – indicate date

To waive (decline) coverage: If you wish to waive Health coverage under the provisions of N.J.S.A. 52:14-17.31a, check appropriate block. **NOTE: Health coverage MUST be waived to avoid paying a contribution.** If you are waiving coverage for yourself or any or all of your eligible dependents because of other group health coverage, you may enroll in the future. You must provide proof of the loss of other coverage and submit it with your application within 60 days of the loss of other coverage. Otherwise you will be required to wait until the annual Open Enrollment.

SECTION 4 – LEVEL OF COVERAGE – Indicate by checking the appropriate block to enroll in a **High Deductible Health Plan (HDHP)**

- **Single** – coverage for you only
- **Parent/Child(ren)** – coverage for you and any eligible child(ren) under age 26
- **Member/Spouse/Civil Union** – coverage for you and your eligible spouse or your Civil Union Partner
- **Member/Domestic Partner** – coverage for you and your eligible Domestic Partner
- **Family** – coverage for you, your eligible Spouse/Civil Union Partner/Domestic Partner, and child(ren) under age 26

SECTION 5 – HEALTH PLAN – Select only one plan. The *Health Benefits Summary Program Description* provides you with all available options at ***www.nj.gov/treasury/pensions/member-guidebooks.shtml*** Employees who choose a HDHP cannot enroll in another prescription drug plan. Prescription drug benefits are provided through the health plan.

**Part-time employees cannot enroll in the NJ DIRECT HD1500 or Aetna Value HD1500 plans.

***SEHBP employees cannot enroll in the NJ DIRECT HD4000 or Aetna Value HD4000 plans.

SECTION 6 – HEALTH SAVINGS ACCOUNT (HSA) – A Health Savings Account (HSA) is only available to employees who enroll in a HDHP. Enrollment in a HSA is voluntary. To enroll, complete a separate Health Savings Account form, which can be found on our website at: ***www.nj.gov/treasury/pensions/hb-forms.shtml*** Your Human Resources representative can answer questions and/or assist you with the completion of the form.

SECTION 7 – DEPENDENT INFORMATION – List all eligible dependents and attach dependent documentation proof (see attached). If proper documentation has already been provided and approved, do not resubmit. If appropriate dependent documentation proof is not provided, dependents may not be enrolled. Ensure your dependents match your level of coverage (Section 4). Your child(ren) may be covered until the end of the calendar year they turn 26. **ANY DEPENDENTS NOT LISTED WILL NOT BE COVERED.**

NOTE: Use Section 3 to delete dependents.

SECTION 8 – EMPLOYEE SIGNATURE – Read, sign, date, and attach required dependent documentation. Return the application to your employer's Human Resources office for certification.

MISREPRESENTATION: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties pursuant to N.J.S.A. 17:33A-6c.

EMPLOYER CERTIFICATION – Must be completed by the Certifying Officer. The Certifying Officer's signature confirms that:

- The employee is eligible;
- The application is legible and completed in its entirety;
- The employee's selected plans and coverage levels are appropriate;
- The dependent documentation provided is complete and correct;
- The Employer Certification section is completed in its entirety; and
- The information presented is true to the best of their knowledge.

MAIL COMPLETED APPLICATION TO: **New Jersey Division of Pensions & Benefits (NJDPB)**
Health Benefits Bureau
P.O. Box 299
Trenton, NJ 08625-02999

HB-0840-1217

State Health Benefits Program (SHBP) • School Employees' Health Benefits Program (SEHBP)

REQUIRED DOCUMENTATION FOR DEPENDENT ELIGIBILITY AND ENROLLMENT

The State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) are required to ensure that only employees, retirees, and eligible dependents are receiving health care coverage under the Programs. The New Jersey Division of Pensions & Benefits (NJDPB) must guarantee consistent application of eligibility requirements within the plans. Employees or retirees who enroll dependents for coverage (spouses, civil union partners, domestic partners, children, disabled and/or overage children continuing coverage) MUST submit the following documentation in addition to the appropriate health benefits enrollment or change of status application. If proper documentation has already been provided and approved, do not resubmit. If appropriate dependent documentation proof is not provided, dependents may not be enrolled. **ANY DEPENDENTS NOT LISTED ON THE APPLICATION WILL NOT BE COVERED.**

DEPENDENTS	ELIGIBILITY DEFINITION	DOCUMENTATION REQUIRED
SPOUSE	A person to whom you are legally married.	A copy of the marriage certificate **and** a copy of the front page of the employee/retiree's federal tax return***** (Form 1040) from last year that includes the spouse. If filing separately, submit a copy of both spouses' tax returns that list the same address. If marriage occurred in the current calendar year, a copy of the tax return is not required. **Or**, if tax return is not available, provide a copy of a bank statement or bill (dated within 90 day of the application) that includes the names of both spouses and is received at the same address.
CIVIL UNION PARTNER	A person of the same sex with whom you have entered into a civil union.	A copy of the marriage certificate **and** a copy of the front page of the employee/retiree's federal tax return***** (Form 1040) from last year that includes the partner. If filing separately, submit a copy of both partners' tax returns that list the same address. If marriage occurred in the current calendar year, a copy of the tax return is not required. **Or**, if tax return is not available, provide a copy of a bank statement or bill (dated within 90 day of the application) that includes the names of both partners and is received at the same address.
DOMESTIC PARTNER	A person of the same sex with whom you have entered into a domestic partnership. Under P.L. 2003, c. 246, the Domestic Partnership Act, health benefits coverage is available to domestic partners of State employees, State retirees, or employees or retirees of a SHBP - or SEHBP - participating local public entity that has adopted a resolution to provide Chapter 246 health benefits.	A copy of the New Jersey certificate of domestic partnership dated prior to February 19, 2007, or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners **and** a copy of the front page of the employee/retiree's N.J. tax return***** from last year that includes the partner. If filing separately, submit a copy of both partners' NJ tax returns that list the same address. If Domestic Partnership occurred in the current calendar year, a copy of the tax return is not required. **Or**, if tax return is not available, provide a copy of a bank statement or bill (dated within 90 days of the application) that includes the names of both partners and is received at the same address.
CHILDREN	A subscriber's child until age 26, regardless of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his or her parents. This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation.	**Natural or Adopted Child** – A copy of the child's birth certificate showing the name of the employee/retiree as a parent. **Step Child** – A copy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent **and** a copy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner. **Legal Guardian, Grandchild, or Foster Child** – Copies of final court orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the employee.
DEPENDENT CHILDREN WITH DISABILITIES	If a covered child is not capable of self-support when he or she reaches age 26 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuance of coverage. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP/SEHBP; (2) the child continues to be disabled; (3) the child is unmarried or does not enter into a civil union or domestic partnership; and (4) the child remains substantially dependent on you for support and maintenance. You may be contacted periodically to verify that the child remains eligible for coverage.	Documentation for the appropriate "child" type (as noted above) **and** a copy of the front page of the employee/retiree's federal tax return***** (Form 1040) from last year that includes the child. If Social Security disability has been awarded, or is currently pending, please include this information with the documentation that is submitted. Please note that this information is only verifying the child's eligibility as a dependent. The disability status of the child is determined through a separate process.
CONTINUED COVERAGE FOR OVERAGE CHILDREN	Certain children over age 26 may be eligible for continued coverage until age 31 under the provisions of P.L. 2005, c. 375. This includes a child by blood or law who: (1) is under the age of 31; (2) is unmarried or not a partner in a civil union or domestic partnership; (3) has no dependent(s) of his or her own; (4) is a resident of New Jersey or is a student at an accredited public or private institution of higher education, with at least 15 credit hours; and (5) is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare.	Documentation for the appropriate "child" type (as noted above), **and** a copy of the front page of the child's federal tax return***** (Form 1040) from last year, and if the child resides outside of the State of New Jersey, documentation of full time student status must be submitted.

*****You may black out all financial information and all but the last four digits of any Social Security numbers on tax returns. To obtain copies of the documents listed above, contact the office of the town clerk in the city of the birth, marriage, etc., or visit these websites: ***www.vitalrec.com*** or ***www.studentclearinghouse.org*** Residents of New Jersey can obtain records from the State Bureau of Vital Statistics and Registration website: ***www.nj.gov/health/vital/index.shtml***

State of New Jersey
Department of the Treasury
Division of Pensions & Benefits (NJDPB)

HA-0780-0917

P.O. Box 299
Trenton, NJ 08625-0299

State Employee Coverage Waiver/Reinstatement
State Health Benefits Program

Part 1: To be completed by the employee. Please print.

1. Name ______________________________ SS# ______________________

Check one box below.

☐ **Waiver of Coverage**

I agree to voluntarily waive State Health Benefits Program (SHBP) coverage to which I am entitled because I am covered under other health coverage. I understand that while coverage is waived, I will not be required to make payroll contributions required for medical and/or prescription drug coverage.

I understand that I may resume State Health Benefits Program coverage if I lose coverage under the other health coverage, provided that I notify the SHBP within 60 days of the loss of the other coverage and provide proof of loss of that coverage.

☐ **Reinstatement of Coverage**

I previously waived State Health Benefits Program coverage because I had other health coverage.

As of ______________________, I am no longer covered by the other health plan, request reinstatement of the State
(date)

Health Benefits Program coverage, and have provided proof of loss of the other coverage. I further understand that coverage is permitted as an employee, retiree, or dependent, however, multiple coverage under the State Health Benefits Program is prohibited.

Employee's Signature ______________________________ **Date** ______________________

Part 2: To be completed by the employer. Check one box below.

☐ We understand that this employee is requesting to voluntarily waive State Health Benefits Program coverage.

☐ We request reinstatement of this employee's State Health Benefits Program coverage.

A completed *State Health Benefits Program Application* must be attached to either a waiver or a reinstatement.

The reinstatement application must be filed within 60 days of the loss of other health coverage. If this timetable is followed, the coverage will be retroactive to the date of loss. If the 60 day time limit has passed, the employee must wait until the next open enrollment period to reenroll.

Employer Name ______________________________ SHBP Location # ______________________

Signature of Certifying Officer ______________________________ Date ______________

Employee Dental Plans

Plan Number	Plan Name	Web Address and Member Services Phone Number
307	Healthplex (International Health Care Services)	www.healthplex.com 1-800-468-0600
317	Horizon Dental Choice.	www.horizonblue.com 1-800-433-6825
319	Aetna DPO	www.aetna.com/statenj 1-800-843-3661
320	MetLife*	www.metlife.com/dental 1-866-880-2984
399	Dental Expense Plan	www.aetna.com/statenj 1-877-STATENJ/1-877-782-8365
305	Cigna Dental Health, Inc.	www.cigna.com/sites/stateofnjdental 1-800-564-7642

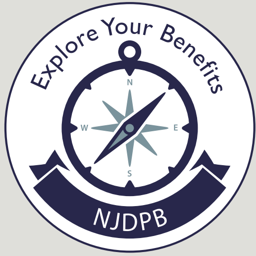
A comparison of dental plan benefits is available in the Employee Dental Plans Fact Sheet

* When searching for a MetLife dental provider on their website, select 'Dental HMO/Managed Care' as the Network Type and whichever Plan Name below that applies to you:

Active Employee	**NJ SHBP/SEHBP Actives**
Retiree Tier 1	NJ SHBP/SEHBP Ret Tier 1
Retiree Tier 2	NJ SHBP/SEHBP Ret Tier 2
Retiree Tier 3	NJ SHBP/SEHBP Ret Tier 3
Retiree Tier 1 (TX)	NJ SHBP/SEHBP Ret Tier 1 (TX)
Retiree Tier 2 (TX)	NJ SHBP/SEHBP Ret Tier 1 (TX)
Retiree Tier 3 (TX)	NJ SHBP/SEHBP Ret Tier 1 (TX)

Not all benefits listed may apply to SHBP or SEHBP members. If there are discrepancies between the information presented on the plan Web pages and the law, regulations, or contracts of the SHBP/SEHBP, the latter will govern. Certain benefits or prescription drugs may require precertification prior to receiving services or purchase. Please contact the health plan for details.

If you have questions or concerns about the information presented, please write to the Health Benefits Bureau, Division of Pensions & Benefits, P.O. Box 299, Trenton, NJ 08625-0299



Dental Plans — Active Employees

Information for:
State Health Benefits Program (SHBP)
School Employees' Health Benefits Program (SEHBP)

ELIGIBILITY

The **Employee Dental Plans** are available to full-time State employees, full-time employees of a local employer (county, municipality, school board, etc.) that elects by resolution to provide the Employee Dental Plans to its employees, and the eligible dependents of these employees. The Employee Dental Plans **are not** available to retirees; for more information on dental plans offered to retirees, see the *Dental Plans - Retirees* Fact Sheet.

New eligible employees may enroll by completing a *N.J. Employee Dental Plans Application* during the first 60 days of employment. The application is available from your Human Resources Representative or Benefits Administrator.

If you do not enroll when first eligible, you have the option to enroll during the annual SHBP/SEHBP Open Enrollment Period. Open Enrollment is normally held in the fall, with coverage effective the following January.

If you do not enroll because of *other* dental coverage and you lose that coverage, you can enroll by submitting an application within 60 days of the loss of coverage.

Once enrolled, you and your eligible dependents must remain in the dental plan you elect for a minimum of 12 months before you can change plans or drop coverage. In the event that you wish to change dental plans, you will not be permitted to do so until the Open Enrollment Period following the 12-month period.

Note: Duplicate coverage within the Employee Dental Plans is not permitted; an individual may be covered as an employee or as a dependent, but not as *both* an employee and a dependent. Children may only be covered by one parent.

DENTAL PLAN CHOICES

You have a choice between two types of dental plans:

- A Dental Plan Organization (DPO); or
- The Dental Expense Plan.

Dental Plan Organizations

The Dental Plan Organizations (DPOs) are companies that contract with a network of providers for dental services. There are several DPOs participating in the Employee Dental Plans from which you may choose. The *Employee Dental Plans Member Guidebook* lists the participating DPOs (see "For More Information" on page 2).

You must use providers who participate with the DPO you select to receive coverage. Be sure you confirm that the dentist or dental facility you select is taking new patients and participates with the SHBP/SEHBP Employee Dental Plans, since DPOs also service other organizations.

When you use a DPO dentist, diagnostic and preventive services are covered in full. Most other eligible expenses require a copayment (see chart on pages 3 and 4). In addition, orthodontic treatment is covered for both children and adults, subject to a copayment.

If your dentist drops out of the DPO, you must select another participating dentist from the DPO. If there are none available within 30 miles of your home, or if you move and your DPO cannot provide a dentist within 30 miles of your home, you may change plans immediately.

Dental Expense Plan

The Dental Expense Plan is a Preferred Provider Organization (PPO) plan administered by Aetna Dental. The plan allows you to choose any licensed dentist for your dental care; however, you will pay less if you use an in-network provider. There is a deductible to satisfy for some services, and some services are eligible only up to a limited amount. The annual plan deductible is $50 per person/$100 per family in-network, and $75 per person/$150 per family out-of-network. The deductible does not apply to diagnostic, preventive, and orthodontic services. After you satisfy the annual deductible, you are reimbursed a percentage of the reasonable and customary charges or PPO-contracted allowance for services that are covered under the plan.

The Dental Expense Plan provides for the following benefits:

- Diagnostic and Preventive Services are paid at 100 percent (in-network) of the PPO-contracted allowance and 90 percent (out-of-network) of the reasonable and customary allowance, with no deductible;
- Basic Services such as fillings and extractions

are paid at 80 percent (in-network) of the PPO-contracted allowance and 70 percent (out-of-network) of the reasonable and customary allowance, after deductible;

- Major Restorative Services, such as crowns, are paid at 65 percent (in-network) of the PPO-contracted allowance and 55 percent (out-of-network) of the reasonable and customary allowance, after deductible;
- Prosthodontic Services for new or replacement dentures are covered at 50 percent (in-network) of the PPO-contracted allowance and 40 percent (out-of-network) of the reasonable and customary allowance, after deductible. Repairs to existing dentures are covered at 80 percent (in-network) of the PPO-contracted allowance and 70 percent (out-of-network) of the reasonable and customary allowances, after deductible;
- Periodontics (treatment of gum disease) is covered at 50 percent (in-network) of the PPO-contracted allowance and 40 percent (out-of-network) of the reasonable and customary allowance, after deductible;
- Orthodontics are available after you have been a full-time employee for 10 months (with no deductible), but only for your children under the age of 19. Orthodontic services are reimbursed at 50 percent (in-network) of the PPO-contracted allowance and 40 percent (out-of-network) of the reasonable and customary allowance, and have a separate $1,000 in-network and $750 out-of-network individual lifetime reimbursement benefit maximum; and
- Benefit Maximum per covered individual is $3,000 annually in-network and $2,000 out-of-network for a maximum of $3,000 combined in- and out-of-network. This maximum applies to all eligible services except orthodontic, which has a separate $1,000/$750 individual lifetime benefit maximum.

With the exception of emergency care, if your Dental Expense Plan treatment includes charges that are expected to cost more than $300, it is strongly recommended that your dentist file for predetermination of benefits with Aetna. With advance approval you will know what services are covered and what payments will be made.

When you use an in-network dental provider, you only pay the provider any applicable deductible and the appropriate coinsurance based on the discounted fee, thereby reducing your out-of-pocket cost. In many cases the in-network dental provider will submit the claims directly to Aetna, eliminating the necessity to file claim forms. To find an in-network provider, call Aetna at 1-877-782-8365.

PREMIUM COSTS

For employees of the State, the premium cost for dental plan coverage is shared between the State and the employee. The amount of your payroll deduction is available from your Human Resources Representative or Benefits Administrator. Dental rates are also posted on the New Jersey Division of Pensions & Benefits (NJDPB) website at: ***www.nj.gov/treasury/pensions***

State employee premiums can be paid on a pre-tax basis through participation in the Premium Option Plan (POP) of Tax$ave — the State's IRC Section 125 program. Participation in the POP is automatic unless you file a form declining participation. The Internal Revenue Service strictly regulates enrollment in the POP and prohibits any benefit changes outside of an Open Enrollment period or unless a qualifying life event occurs (e.g., loss of other coverage, marriage, divorce, etc.). The *Tax$ave* Fact Sheet explains the POP in more detail.

For employees of a participating local employer, the premium cost for dental plan coverage will vary based upon the policies of that employer, with regard to health benefit costs and any labor agreements between the employer and the unions representing the employee. Employees of a participating local employer should see their Human Resources Representative or Benefits Administrator for more information.

CHOOSING A DENTAL PLAN

Your choice of a dental plan is a personal decision. In deciding whether to enroll and which plan to choose, you should consider:

- The nature and amount of your anticipated dental expenses for the next year;
- The covered services provided by the Dental Expense Plan or a DPO;
- The differences in out-of-pocket costs for each type of plan; and
- The degree of flexibility that you may want in selecting a dentist.

You can use the summary chart on pages 3 and 4 of this fact sheet to compare benefit levels under each type of dental plan. If you choose a DPO, you must select a dentist who participates with that particular DPO and who can accept you and your dependents as patients.

FOR MORE INFORMATION

For more information on the Employee Dental Plans or the names and phone numbers for the individual dental plans, see the *Employee Dental Plans Member Guidebook*, available on our website at: ***www.nj.gov/treasury/pensions***

This fact sheet has been produced and distributed by:

New Jersey Division of Pensions & Benefits
P.O. Box 295, Trenton, NJ 08625-0295

(609) 292-7524
For the hearing impaired: TRS 711 (609) 292-6683
www.nj.gov/treasury/pensions

PLAN COMPARISON — The following chart provides a summary description of a variety of dental services under the two types of dental plans offered by the Employee Dental Plans. The chart is not complete and does not describe all the benefits, limitations, or conditions associated with coverage under either type of plan. Please refer to the Employee Dental Plans Member Guidebook for additional details.

	DENTAL EXPENSE PLAN		DENTAL PLAN ORGANIZATION (DPO)
	IN-NETWORK	OUT-OF-NETWORK	
Deductible	$50 per person per calendar year / $100 per family; None for diagnostic/ preventive and orthodontic services	$75 per person per calendar year / $150 per family; None for diagnostic/ preventive and orthodontic services	None
Coinsurance	Plan pays: 100% Diagnostic and Preventive 80% Basic Restorative; 65% Major Restorative; 50% Periodontics and Prosthodontics[1]	Plan pays: 90% Diagnostic and Preventive; 70% Basic Restorative; 55% Major Restorative; 40% Periodontics and Prosthodontics[1]	Plan pays 100% (less copayment); 100% Diagnostic and Preventive
Copayments	None	None	Varies depending on service
Benefits Maximum	$3,000 (Maximum of $3,000 combined in- and out-of-network) per member annually (excluding orthodontics); $1,000 (lifetime) per child for orthodontics	$2,000 (Maximum of $3,000 combined in- and out-of-network) per member annually (excluding orthodontics); $750 (lifetime) per child for orthodontics	Unlimited
Provider Limitations	Must use participating dentist	Any licensed dentist	Must use DPO-participating dentist
Selected Services	**Some services listed below may be covered subject to deductibles and coinsurance as shown above**	**Some services listed below may be covered subject to deductibles and coinsurance as shown above**	**Services listed below are covered in full subject to copayments**
Examinations	Oral evaluations limited to twice per calendar year; Plan pays 100%[1]	Oral evaluations limited to twice per calendar year; Plan pays 90%[1]	Oral evaluations limited to twice per calendar year; Plan pays 100%
X-Rays	Covered subject to limitations; Plan pays 100%[1]	Covered subject to limitations; Plan pays 90%[1]	Covered subject to limitations; Plan pays 100%
Cleanings (Oral Prophylaxis)	Two cleanings per calendar year; Plan pays 100%[1]	Two cleanings per calendar year; Plan pays 90%[1]	Two cleanings per calendar year; Plan pays 100%
Fluoride Applications	Covered only for children under age 19; Twice per calendar year; Plan pays 100%[1]	Covered only for children under age 19; Twice per calendar year; Plan pays 90%[1]	Covered only for children under age 19; Twice per calendar year; Plan pays 100%

[1] In the Dental Expense Plan, you are responsible for the amount the dentist charges above the reasonable and customary allowances.

Dental Plans — Active Employees

	DENTAL EXPENSE PLAN		DENTAL PLAN ORGANIZATION (DPO)
	IN-NETWORK	OUT-OF-NETWORK	
Tooth Sealants	Covered for children under age 19 (with restrictions); Plan pays 100%[1]	Covered for children under age 19 (with restrictions); Plan pays 90%[1]	Covered only for children under age 19; No copayment (limitations apply)
Routine Fillings	Plan pays 80%[1]	Plan pays 70%[1]	Covered; Copayments may apply[2]
Simple Extraction	Plan pays 80%[1]	Plan pays 70%[1]	Covered after copayment of $20
Crowns	Plan pays 65%[1]	Plan pays 55%[1]	Covered after copayment of $150–$225[2]
Root Canal (Endodontics)	Plan pays 80%[1]	Plan pays 70%[1]	Endodontic Therapy covered after copayment of $100–$175[2]
Dentures	Repair of existing dentures covered at 80%[1]; New or replacement dentures covered at 50%[1]	Repair of existing dentures covered at 70%[1]; New or replacement dentures covered at 40%[1]	Covered after copayment (with limitations)[2]
Oral Surgery for Removal of Impacted Tooth	Plan pays 80%[1]; May be covered under the medical plan first then dental will consider	Plan pays 70%[1]; May be covered under the medical plan first then dental will consider	Covered after copayment of $65
Periodontics	Plan pays 50% (with limitations)	Plan pays 40% (with limitations)	Covered after copayment of: $30 for gingivectomy (one to three teeth); $55 for root planing (per quadrant); $100–$175[2] for osseous surgery
Orthodontic	After you have been an employee for 10 months, eligible services covered at a 50% coinsurance level, up to a $1,000 lifetime maximum per child; Covered only for those who start treatment before age 19 (See *Employee Dental Plans Member Guidebook* for specifics)	After you have been an employee for 10 months, eligible services covered at a 40% coinsurance level, up to a $750 lifetime maximum (maximum of $1,000 combined in and out-of-network) per child; Covered only for those who start treatment before age 19 (See *Employee Dental Plans Member Guidebook* for specifics)	Maximum treatment is 24 months; Copayment as follows: Patient under age 18: $1000 or 50% of bill, whichever is less; Patient age 18 or over: $1,750 or 50% of bill, whichever is less

[1] *In the Dental Expense Plan, you are responsible for the amount the dentist charges above the reasonable and customary allowances.*

[2] *See the Employee Dental Plans Member Guidebook for DPO copayment amounts.*

Continuation of Health Benefits Under COBRA

Information for:
State Health Benefits Program (SHBP)
School Employees' Health Benefits Program (SEHBP)

INTRODUCTION

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 requires that most employers sponsoring group health plans offer employees and their eligible dependents — also known under COBRA as "qualified beneficiaries" — the opportunity to temporarily extend their group health coverage in certain instances where coverage under the plan would otherwise end. For State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) participants, COBRA is not a separate health program; it is a continuation of SHBP or SEHBP coverage under the provisions of the federal law.

ELIGIBILITY FOR COBRA

Please Note: Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at ***www.healthcare.gov***

Employees enrolled in the SHBP or SEHBP may continue coverage under COBRA, in any plan that the employee is eligible for, if coverage ends because of a:

- Reduction in working hours;
- Leave of absence; or
- Termination of employment for reasons other than gross misconduct.

Note: Employees who at retirement are eligible to enroll in SHBP or SEHBP Retired Group coverage cannot enroll for health benefit coverage under COBRA.

Spouses, civil union partners, or eligible same-sex domestic partners* of employees enrolled in the SHBP or SEHBP may continue coverage under COBRA, in any plan that the employee is eligible for, if coverage ends because of the:

- Death of the employee;
- End of the employee's coverage due to a reduction in working hours, leave of absence, or termination of employment for reasons other than gross misconduct;
- Divorce or legal separation of the employee and spouse;
- Dissolution of a civil union or domestic partnership; or
- Election of Medicare as the employee's primary insurance carrier (requires dropping the group coverage carried as an active employee).

Children under age 26 may continue coverage under COBRA if the following occurs:

- Death of the employee;
- End of the employee's coverage due to a reduction in working hours, leave of absence, or termination of employment for reasons other than gross misconduct; or
- Election of Medicare as the employee's primary insurance carrier (requires dropping the group coverage carried as an active employee).

Note: Each "qualified beneficiary" may independently elect COBRA coverage to continue in any or all of the coverage you had as an active employee or dependent (medical, prescription drug, dental, and/or vision). You and/or your dependents may change your medical and/or dental plan when you enroll in COBRA. You may also elect to cover the same dependents you had as an active employee, or you can delete dependents to reduce your level of coverage. However, you cannot increase the level of your coverage, except during the annual Open Enrollment period, unless a qualifying event occurs (birth, adoption, marriage, civil union, eligible domestic partnership) and you notify the Division of Pensions and Benefits' COBRA Administrator within 60 days of the qualifying event.

**For more information about health benefits for domestic partners, including eligibility requirements, see Fact Sheet #71, Benefits Under the Domestic Partnership Act. For more information about health benefits for civil union partners see Fact Sheet #75, Civil Unions.*

DURATION OF COBRA COVERAGE

The length of your COBRA coverage continuation depends on the nature of the COBRA qualifying event that entitled you to the coverage.

- For loss of coverage due to termination of employment, reduction of hours, or leave of absence, the employee and/or dependents are entitled to 18 months of COBRA coverage. Time on leave of absence just before enrollment in COBRA, *unless under the federal and/or State Family Leave Act,* counts toward the 18-month period and will be subtracted from the 18 months. Time a member spends on federal or State leave *will not* count as part of the COBRA eligibility period.
- If you receive a Social Security Administration disability determination for an illness or injury you had when you enrolled in COBRA or incurred within 60 days of enrollment, you and your covered dependents are entitled to an extra 11 months of coverage up to a maximum of 29 months of COBRA coverage. You must provide proof within 60 days of the disability determination from the Social Security Administration or within 60 days of COBRA enrollment.
- For loss of coverage due to the death of the employee, divorce or legal separation, dissolution of a civil union or domestic partnership, other dependent ineligibility, or Medicare entitlement, the continuation term for dependents is 36 months.

COST OF COVERAGE

You are responsible for paying the cost of your coverage under COBRA which is the full group rate plus a two percent administrative fee. The Division of Pensions and Benefits will bill you on a monthly basis.

EMPLOYEE / QUALIFIED BENEFICIARY RESPONSIBILITIES UNDER COBRA

The law requires that employees and/or their dependents:

- Keep your employer and the Division of Pensions and Benefits informed of any changes to the address information of all possible "qualified beneficiaries."
- Notify your employer that a divorce, legal separation, dissolution of a civil union or domestic partnership, or the death of the employee has occurred or that a covered child has reached age 26 — notification must be given within 60 days of the date the event occurred (If you do not inform your employer of the change in dependent status within the 60-day requirement, you may forfeit your dependent's right to COBRA);
- File a *COBRA Application* within 60 days of the loss of coverage or the date of the *COBRA Notice* provided by your employer, whichever is later;
- Pay the required monthly premiums in a timely manner;
- Pay premiums, when billed, retroactive to the date of group coverage termination;
- Notify the Division of Pensions and Benefits' COBRA Administrator, in writing, of any second qualifying event that results in an extension of the maximum coverage period (see "Duration of COBRA Coverage" above);
- Notify the Division of Pensions and Benefits' COBRA Administrator, in writing, of a Social Security Administration disability award within 60 days of receipt of the award, or within 60 days of COBRA enrollment (this will extend the maximum COBRA coverage period from 18 months to 29 months — see "Duration of COBRA Coverage" above); and
- Provide notice of any determination that a "qualified beneficiary" who had received a disability extension is no longer disabled. This notice must be sent to the Division of Pensions and Benefits' COBRA Administrator within 30 days of determination by the Social Security Administration. Failure to provide timely notification may result in adjustments to any claims paid erroneously.

EMPLOYER RESPONSIBILITIES UNDER COBRA

The COBRA law requires employers to:

- Notify employees and their dependents of the COBRA provisions within 90 days of when the employee and their dependents are first enrolled in the SHBP or SEHBP by mailing a notification letter to their home;
- Notify employees, their spouse or partner, and their children of the right to purchase continued coverage within 14 days of receiving notice that there has been a COBRA qualifying event that causes a loss of coverage;
- Send the *COBRA Notification Letter* and a *COBRA Application* within 14 days of receiving notice that a COBRA qualifying event has occurred. The notice outlines the right to purchase continued health coverage, gives the date coverage will end, and the period of time over which coverage may be extended;
- Notify the Division of Pensions and Benefits within 30 days of the date of an employee/ dependent's qualifying event or loss of coverage. (An employee's loss of coverage is reported by completing a *Transmittal of Deletions Sheet.* A dependent's loss of coverage is reported through the Division's receipt of a completed health benefit application terminating the dependent's coverage.)

- Maintain records documenting their compliance with the COBRA law.

ENROLLING FOR COBRA COVERAGE

The employee and/or the dependent seeking coverage is responsible for submitting a properly completed *COBRA Application* to the Health Benefits Bureau of the Division of Pensions and Benefits. This application must be filed within 60 days of the loss of coverage or of the date of employer notification, whichever is later. **Failure to submit the application within the time frame allowed by law is considered a decision not to enroll.**

- In considering whether to elect continuation of coverage under COBRA, you should take into account that you *cannot* enroll at a later date and that a failure to continue your group health coverage may affect your future rights under federal law (see "Failure to Elect COBRA Coverage", on page 4).
- *If you are retiring,* you may be eligible for lifetime health, prescription drug, and dental coverage through the Retired Group of the SHBP or SEHBP. If you are eligible for retired group coverage, you are not eligible to continue coverage under COBRA. Consult your employer or the Division of Pensions and Benefits *prior to* your retirement date.

FAILURE TO ELECT COBRA COVERAGE

In considering whether to elect continuation of coverage under COBRA, a "qualified beneficiary" should take into account that a failure to continue group health coverage will affect future rights under federal law.

You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's/partner's employer) within 30 days of the date your group coverage ends. You will also have the same special enrollment right at the end of the COBRA coverage period provided the continuation of coverage under COBRA is for the maximum time available to you.

AFTER YOU HAVE ENROLLED IN COBRA

You should be aware of the following information after you have enrolled in COBRA:

- Bills will be sent from the Division of Pensions and Benefits/Health Benefits Bureau. Any billing questions must be referred to the:

  COBRA Administrator
  Division of Pensions and Benefits
  Health Benefits Bureau
  PO Box 299
  Trenton, NJ 08625-0299

  or you may call the Division's Office of Client Services at (609) 292-7524.
- You will be billed monthly. Accounts delinquent over 45 days will be closed and insurance coverage terminated retroactively to the date of last payment, or to the end of the month in which claims were submitted. If you do not receive a monthly bill or misplace it, contact the Office of Client Services. **It is your responsibility to make payment on a timely basis.**
- Once you are enrolled in COBRA, claims are handled just like active employee claims (i.e. using the same claim forms and procedures). However, you must indicate your status as a COBRA participant on all claim forms (this will help prevent claim processing issues.) All COBRA premiums must also be paid through the date of the claim in order for the claim to be processed.) **Questions about claims should be directed to the insurance carriers.** The single exception is that vision plan claims are sent directly to the COBRA Administrator at the address shown above.
- Plan administration under COBRA follows the same rules as for active employees. However, all activity is processed through the COBRA Administrator rather than the former employer. COBRA subscribers are permitted to change medical and/or dental plans and/or add coverage during the annual Open Enrollment period (in the fall) through the COBRA Administrator. All COBRA enrollees will receive Open Enrollment information mailed directly to their address on file with the SHBP or SEHBP.
- All changes in coverage due to a "qualifying event" (for example: the birth of a child, a marriage, civil union, divorce, a death, etc.) must be made in writing to the COBRA Administrator at the address previously provided.

  Upon receipt of your letter, you will be sent a COBRA change form. To increase coverage, you have 60 days from the date of the qualifying event to make the change. To change plans, because you have moved out of your plan's service area, you have 30 days to make the change. These changes must be requested within the specified time frames, otherwise they may only be made during the Open Enrollment period. You may decrease your coverage (delete a dependent) at any time.

TERMINATION OF COBRA COVERAGE

Your COBRA benefits under the SHBP or SEHBP will terminate for any of the following reasons:

- Your employer (or former employer) no longer provides SHBP or SEHBP coverage to any of its employees. In this case, your employer will give you the opportunity to continue COBRA coverage through their new insurance plan for the balance of your COBRA continuation period;

- You become eligible for Medicare after you elect COBRA coverage (affects medical insurance coverage only, does not affect dental, prescription drug, or vision care coverage);
- You fail to pay your premiums; or
- Your eligible coverage continuation period ends.

CONVERSION OF COBRA COVERAGE

The COBRA law provides that you must be allowed to enroll in an individual, non-group policy of the same health plan provided under the SHBP or SEHBP at the end of your COBRA enrollment period. You must complete your full coverage continuation period. Contact the health plan for details.

Note: There are no conversion provisions for prescription drug or dental coverage.

MORE INFORMATION

If you need additional information about COBRA, see your Human Resources Representative or Benefits Administrator, or contact the Division of Pensions and Benefits Office of Client Services at (609) 292-7524, or send an e-mail to: ***pensions.nj@treas.nj.gov***

A NOTE ABOUT COVERAGE FOR CHILDREN AGE 26 UNTIL AGE 31

The Division of Pensions and Benefits has specific guidelines about providing health coverage to children past the age of 26 until age 31 due to the enactment of Chapter 375, P.L. 2005. A child who attains age 26 and needs continued coverage can select either COBRA coverage or Chapter 375 coverage for medical benefits. Rates for COBRA coverage and Chapter 375 coverage can change annually, be sure to compare the rates prior to enrolling in either program.

Please note that if the child opts to enroll in Chapter 375, he/she will not be permitted to enroll in COBRA once enrollment in Chapter 375 terminates.

Chapter 375 does not cover vision or dental benefits. If your child wishes to obtain those coverages, he/she must apply for them under COBRA.

The eligibility requirements for Chapter 375 are outlined in Fact Sheet #74, *Health Benefit Coverage of Children Until Age 31 Under Chapter 375,* which is available on our Web site.

This fact sheet has been produced and distributed by:

New Jersey Division of Pensions and Benefits
PO Box 295, Trenton, New Jersey 08625-0295

(609) 292-7524
For the hearing impaired: TRS 711 (609) 292-6683
www.nj.gov/treasury/pensions

HD-0719-0717

State Health Benefits Program (SHBP) • School Employees' Health Benefits Program (SEHBP)

HEALTH BENEFITS ACTIVE EMPLOYEE GROUP

EMPLOYEE DENTAL ENROLLMENT and/or CHANGE FORM

1. EMPLOYEE INFORMATION — Last Name | First | MI

Gender | Birth Date / / | Social Security Number — — | Marital Status*

Telephone Number ( ) | Personal E-mail Address

Home Address No. and Street Name

City | State | Zip

DIVISION USE ONLY

Effective Dates D ____ ____ ____ Event Reason: ☐

EMPLOYER CERTIFICATION

(See Instructions on reverse)

Employer Name ______________________

Payroll # ______________________
(State Biweekly)

Union Code(Rx) Only ☐☐

Location #
(State Monthly or Local /Education)

☐☐☐☐ - ☐☐

10/12 - month employee ☐☐
(Enter "10 or 12")

MEMBER ACTION

☐ New Enrollment ☐ Transfer

Date Employment Began

_____/_____/_____

☐ Return from Leave of Absence

_____/_____/_____

Signature of Certifying Officer

Telephone # *Date Mailed*

2. REASON FOR APPLICATION *(check one)*

- ☐ New Enrollment
- ☐ Transfer
- ☐ Open Enrollment
- ☐ Loss of Coverage
- ☐ Adding Dependents
- ☐ Deleting Dependents
- ☐ Waiver of Coverage
- ☐ Other

Reason____

Date of Event ________/________/________

3. LEVEL OF COVERAGE

- ☐ Single
- ☐ Parent/Child
- ☐ Member/Spouse/Civil Union
- ☐ Member/Domestic Partner
- ☐ Family

4. DENTAL PLAN You must remain enrolled in selected plan for 12 months.

I wish to be covered under a Dental Plan Organization (DPO)*

☐ Aetna DMO ☐ Cigna ☐ MetLife ☐ Healthplex ☐ Horizon BCBSNJ

☐ **I wish to be covered under the Dental Expense Plan (Aetna DEP)***

☐ I have been offered the above coverage and **I elect to waive participation** for myself and my eligible dependents. *

5. Dependent Information: List all eligible dependents and attach required proof of dependency documents*

☐ **Additional sheets attached. Any dependents not listed will be removed.**

Eligible Dependents Last Name, First Name	Social Security No.	Circle Relationship	Birth Date	Gender
	— —	Spouse / Civil Union / Domestic Partner	/ /	
	— —	Child *(Natural, Adopted, Foster, Step, Legal Ward)*	/ /	
	— —	Child *(Natural, Adopted, Foster, Step, Legal Ward)*	/ /	
	— —	Child *(Natural, Adopted, Foster, Step, Legal Ward)*	/ /	

***See Instructions page for detailed information and Mailing Address**

EMPLOYEE CERTIFICATION — I certify that all the information supplied on this form is true to the best of my knowledge and that it is verifiable. I understand that if I waive my right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment or if other coverage is lost and proof of loss is provided (HIPAA). I understand that I must remain enrolled in the Dental Plan for a minimum of 12 months and that there is no guarantee of continuous participation by dental service providers, either dentists or facilities, in the DPO plans. If either my dentist or dental center terminates participation in my selected plan, I must select another dentist or dental center participating in that plan to receive the "in-network" benefit. I authorize any hospital, physician, dentist or dental care provider to furnish my dental plan or its assignee with such dental information about myself or my covered dependents as the assignee may require. Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties pursuant to N.J.S.A.17:33A-6c.

6. Employee Signature: ____ **Date:** _____/_____/_____

INSTRUCTIONS FOR THE NEW JERSEY EMPLOYEE DENTAL PLANS ENROLLMENT and/or CHANGE FORM

SECTION 1 – EMPLOYEE INFORMATION – Complete entire section. Indicate Marital Status as follows: **S** (Single), **M** (Married), **CU** (Civil Union), **DP** (Domestic Partner), **D** (Divorced), W (Widowed)

SECTION 2 – REASON FOR APPLICATION – Check one block only

- **New Enrollment** – New hire or HIPAA event
- **Transfer** – Active dental benefits coverage transferring from another SHBP/SEHBP location
- **Open Enrollment** – Annually in October
- **Adding Dependents** – Must be done within 60 days of event (i.e. birth, marriage, adoption – indicate reason and date)
- **Deleting Dependents** – Removal of covered dependents (indicate reason and date)
- **Loss of Coverage** – Enrolling because of loss of other coverage (application and HIPAA certificate submitted within 60 days of the loss of other coverage)
- **Waiver of Coverage** – Waive (decline) coverage
- **Other** (indicate reason and date)
- **Reason** – indicate reason
- **Date of Event** – indicate date

To waive (decline) coverage: If you wish to waive Dental coverage under the provisions of N.J.S.A. 52:14-17.31a, check appropriate block. If you are waiving coverage for yourself or any or all of your eligible dependents because of other group health coverage, you may enroll in the future. You must provide proof of the loss of other coverage and submit it with your application within 60 days of the loss of other coverage. Otherwise, you will be required to wait until the annual Open Enrollment.

SECTION 3 – LEVEL OF COVERAGE – Indicate by checking the appropriate block

- **Single** – coverage for you only
- **Parent/Child(ren)** – coverage for you and any eligible child(ren) under age 26
- **Member/Spouse/Civil Union** – coverage for you and your spouse or your Civil Union Partner
- **Member/Domestic Partner** – coverage for you and your Domestic Partner
- **Family** – coverage for you, your eligible Spouse/Civil Union Partner/Domestic Partner, and child(ren) under age 26

SECTION 4 – DENTAL PLAN – Select only one plan. The *Employee Dental Plans Member Guidebook* provides you with all available options at ***www.nj.gov/treasury/pensions/member-guidebooks.shtml*** If you enroll in a Dental Plan Organization (DPO), you must receive services from an in-network dentist in order to have your claims paid. You must select a participating dentist within the DPO, ensuring the dentist or facility takes new patients and participates with the Employee Dental Plans. If you enroll in the Dental Expense Plan (Aetna DEP), you may receive services from any dentist. You will be required to pay up-front for covered services until a deductible is met.

IMPORTANT: After you enroll in a Dental Plan you must remain enrolled for 12 months until you are permitted to terminate coverage.

SECTION 5 – DEPENDENT INFORMATION – List all eligible dependents and attach dependent documentation proof (see attached). If proper documentation has already been provided and approved, do not resubmit. If appropriate dependent documentation proof is not provided, dependents may not be enrolled. Ensure your dependents match your level of coverage (Section 4). Your child(ren) may be covered until the end of the calendar year they turn 26. **ANY DEPENDENTS NOT LISTED WILL NOT BE COVERED.**

Note: Use Section 2 to delete dependents

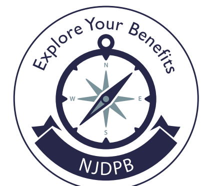
SECTION 6 – EMPLOYEE SIGNATURE – Read, sign, date, and attach required dependent documentation. Return the application to your employer's Human Resources office for certification.

MISREPRESENTATION: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties pursuant to N.J.S.A. 17:33A-6c.

EMPLOYER CERTIFICATION – Must be completed by the Certifying Officer. The Certifying Officer's signature confirms that:

- The employee is eligible;
- The application is legible and completed in its entirety;
- The employee's selected plans and coverage levels are appropriate;
- The dependent documentation provided is complete and correct;
- The Employer Certification section is completed in its entirety; and
- The information presented is true to the best of their knowledge.

MAIL COMPLETED APPLICATION TO: **New Jersey Division of Pensions & Benefits (NJDPB)**
Health Benefits Bureau
P.O. Box 299
Trenton, NJ 08625-0299



HB-0840-1217

State Health Benefits Program (SHBP) • School Employees' Health Benefits Program (SEHBP)

REQUIRED DOCUMENTATION FOR DEPENDENT ELIGIBILITY AND ENROLLMENT

The State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) are required to ensure that only employees, retirees, and eligible dependents are receiving health care coverage under the Programs. The New Jersey Division of Pensions & Benefits (NJDPB) must guarantee consistent application of eligibility requirements within the plans. Employees or retirees who enroll dependents for coverage (spouses, civil union partners, domestic partners, children, disabled and/or overage children continuing coverage) MUST submit the following documentation in addition to the appropriate health benefits enrollment or change of status application. If proper documentation has already been provided and approved, do not resubmit. If appropriate dependent documentation proof is not provided, dependents may not be enrolled. **ANY DEPENDENTS NOT LISTED ON THE APPLICATION WILL NOT BE COVERED.**

DEPENDENTS	ELIGIBILITY DEFINITION	DOCUMENTATION REQUIRED
SPOUSE	A person to whom you are legally married.	A copy of the marriage certificate **and** a copy of the front page of the employee/retiree's federal tax return* (Form 1040) from last year that includes the spouse. If filing separately, submit a copy of both spouses' tax returns that list the same address. If marriage occurred in the current calendar year, a copy of the tax return is not required. **Or**, if tax return is not available, provide a copy of a bank statement or bill (dated within 90 day of the application) that includes the names of both spouses and is received at the same address.
CIVIL UNION PARTNER	A person of the same sex with whom you have entered into a civil union.	A copy of the marriage certificate **and** a copy of the front page of the employee/retiree's federal tax return* (Form 1040) from last year that includes the partner. If filing separately, submit a copy of both partners' tax returns that list the same address. If marriage occurred in the current calendar year, a copy of the tax return is not required. **Or**, if tax return is not available, provide a copy of a bank statement or bill (dated within 90 day of the application) that includes the names of both partners and is received at the same address.
DOMESTIC PARTNER	A person of the same sex with whom you have entered into a domestic partnership. Under P.L. 2003, c. 246, the Domestic Partnership Act, health benefits coverage is available to domestic partners of State employees, State retirees, or employees or retirees of a SHBP - or SEHBP - participating local public entity that has adopted a resolution to provide Chapter 246 health benefits.	A copy of the New Jersey certificate of domestic partnership dated prior to February 19, 2007, or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners **and** a copy of the front page of the employee/retiree's N.J. tax return* from last year that includes the partner. If filing separately, submit a copy of both partners' NJ tax returns that list the same address. If Domestic Partnership occurred in the current calendar year, a copy of the tax return is not required. **Or**, if tax return is not available, provide a copy of a bank statement or bill (dated within 90 days of the application) that includes the names of both partners and is received at the same address.
CHILDREN	A subscriber's child until age 26, regardless of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his or her parents. This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation.	**Natural or Adopted Child** – A copy of the child's birth certificate showing the name of the employee/retiree as a parent. **Step Child** – A copy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent **and** a copy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner. **Legal Guardian, Grandchild, or Foster Child** – Copies of final court orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the employee.
DEPENDENT CHILDREN WITH DISABILITIES	If a covered child is not capable of self-support when he or she reaches age 26 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuance of coverage. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP/SEHBP; (2) the child continues to be disabled; (3) the child is unmarried or does not enter into a civil union or domestic partnership; and (4) the child remains substantially dependent on you for support and maintenance. You may be contacted periodically to verify that the child remains eligible for coverage.	Documentation for the appropriate "child" type (as noted above) **and** a copy of the front page of the employee/retiree's federal tax return* (Form 1040) from last year that includes the child. If Social Security disability has been awarded, or is currently pending, please include this information with the documentation that is submitted. Please note that this information is only verifying the child's eligibility as a dependent. The disability status of the child is determined through a separate process.
CONTINUED COVERAGE FOR OVERAGE CHILDREN	Certain children over age 26 may be eligible for continued coverage until age 31 under the provisions of P.L. 2005, c. 375. This includes a child by blood or law who: (1) is under the age of 31; (2) is unmarried or not a partner in a civil union or domestic partnership; (3) has no dependent(s) of his or her own; (4) is a resident of New Jersey or is a student at an accredited public or private institution of higher education, with at least 15 credit hours; and (5) is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare.	Documentation for the appropriate "child" type (as noted above), **and** a copy of the front page of the child's federal tax return* (Form 1040) from last year, and if the child resides outside of the State of New Jersey, documentation of full time student status must be submitted.

You may black out all financial information and all but the last four digits of any Social Security numbers on tax returns. To obtain copies of the documents listed above, contact the office of the town clerk in the city of the birth, marriage, etc., or visit these websites: ***www.vitalrec.com or ***www.studentclearinghouse.org***
Residents of New Jersey can obtain records from the State Bureau of Vital Statistics and Registration website: ***www.nj.gov/health/vital/index.shtml***