
A PUBLICATION OF THE NEW JERSEY DIVISION OF PENSIONS AND BENEFITS

HEALTH BENEFITS COVERAGE FOR PART-TIME EMPLOYEES

State Health Benefits Program and School Employees Health Benefits Program

INTRODUCTION

Chapter 172, P.L. 2003 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 for coverage 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 employee can only enroll in **NJ DIRECT15** and the **Employee Prescription Drug Plan**. These plans are described at the end of this fact sheet. If an eligible employee or faculty member elects to enroll and purchase coverage, the employee or faculty member 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 below**. If a specific topic is not outlined in this publication, please refer to the information provided in the *NJ DIRECT15 Member Handbook* or the *Employee Prescription Drug Plan Member Handbook*.

ELIGIBILITY AND ENROLLMENT

Part-time Active Employee Eligibility

Eligibility for coverage is determined by the Division of Pensions and Benefits. Enrollments, terminations, changes to contracts, etc. must be processed through your employer first, then the by the Division. If you have any questions concerning eligibility provisions, you should see your employer or call the Division of Pensions and Benefits' 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, or the Alternate Benefit 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 unmarried children (including step-children, legally adopted children, foster children, legal wards) under the age of 23 who are substantially dependent upon you for support and maintenance and who:
 - Live with you in a parent-child relationship; or
 - Reside at school but who have a permanent domicile with you and whom you support; or
 - Do not live with you, but whom you are legally required to support. Proof of the legal requirement of support is necessary.

Enrollment

You cannot be covered by the health benefits provided under Chapter 172, P.L. 2003, until you enroll in **both** a New Jersey State-administered retirement system and SHBP or SEHBP. When you become

*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*.

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eligible for enrollment in a retirement system, your employer will provide you with the *Part-Time Employees Group of the SHBP/SEHBP 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 NJ DIRECT15** and the Employee Prescription Drug Plan coverage, **or** they may select NJ DIRECT15 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 Division's Internet home page at: www.state.nj.us/treasury/pensions/shbp.htm

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 "Change of Coverage" section of the *NJ DIRECT15 Member Handbook*). Open Enrollment periods generally occur once a year. Information concerning the duration of the Open Enrollment period and effective dates of coverage are announced by the Division of Pensions and Benefits.

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 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 dependent's coverage is effective the same date as your coverage is effective.

Changes in Coverage

Coverage changes involving the addition of dependents are effective retroactive to the date of the event (marriage, civil union, eligible domestic partnership, birth, adoption, etc.) providing 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. Dependent children are automatically terminated as of the end of the year they attain age 23.

Leave-of-Absence

If you take an approved leave-of absence, your SHBP 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 NJ DIRECT15 COVERAGE

Retiree Eligibility

Upon retirement, part-time State employees and part-time faculty members who are enrolled in the SHBP under the provisions of Chapter 172, are permitted to enroll in retired group **NJ DIRECT15** coverage provided that they continue to pay the full cost of their retiree coverage. Prescription drug coverage for retirees is provided through NJ DIRECT15 — **retirees are not eligible for the Employee Prescription Drug Plan**.

Retirees should also see the Division's provisions regarding the requirement to be enrolled in Medicare Part A and Part B coverage, as outlined in the *NJ DIRECT Member Handbook*.

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Note: Health benefits coverage under the provisions of Chapter 172 does not qualify an employee for State-paid or employer-paid post-retirement health care benefits under the SHBP or SEHBP.

COBRA COVERAGE

Upon termination of SHBP coverage provided under Chapter 172, continued coverage in NJ DIRECT15 and the Employee Prescription Drug Plan is available under federal COBRA legislation. See the *NJ DIRECT Member Handbook* and the *Employee Prescription Drug Plan Member Handbook* for more information, which is available on our Web site at www.state.nj.us/treasury/pensions

PURCHASE OF INDIVIDUAL INSURANCE COVERAGE

Part-time State employees and part-time faculty members who are eligible to enroll under provisions of Chapter 172, **are not eligible** for other health coverage plans available under the provisions of the New Jersey Individual Health Coverage Program (IHCP). If you are covered under the IHCP and eligible for coverage under Chapter 172, you must contact the carrier regarding cancellation of your IHCP benefits. You may re-enroll in the IHCP during the IHCP's October open enrollment period (for a January effective date). If your SHBP benefits terminate, you are immediately eligible for coverage in the individual market. To avoid the possibility of the application of a preexisting condition waiting period, you must obtain individual coverage within 31 days of the loss of your coverage.

Additional information about the IHCP 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: www.njdoib.org

PLAN DESCRIPTIONS

NJ DIRECT15

NJ DIRECT15 is a Preferred Provider Organization (PPO). It provides managed care to its members through its own network of providers. It also offers out-of-network benefits that provides reimbursement to providers and members for expenses for services rendered for the treatment of illness and injury.

NJ DIRECT15 is currently administered for the SHBP by Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) which means that Horizon BCBSNJ is the claims payer for all covered members.

NJ DIRECT15 offers:

- A network of providers, which includes primary care physicians (PCP) internists, general practitioners, pediatricians, specialists, and hospitals.
- A full range of services when you use network providers to include well-care and preventive services such as annual physicals, well-baby/well-child care, immunizations, mammograms, annual gynecological examinations, and prostate examinations.
- In-network services, which are generally covered in full after a small copayment. The copayment amount varies depending on the contract agreement between the labor union that represents you as an employee (see below).
- No filing of claim forms when you use in-network services.
- In-network hospital admissions covered in full.
- An out-of-network option whereby you may use providers who are not in the network and receive a 70 percent reimbursement of the reasonable and customary allowance for most care after a deductible is met.

For more information about NJ DIRECT15, see the *NJ DIRECT Member Handbook* which is available from your employer, by contacting the Division of Pensions and Benefits, or online at: www.state.nj.us/treasury/pensions/shbp.htm

Employee Prescription Drug Plan

The Employee Prescription Drug Plan is a separate drug plan for active employees. The plan is currently administered by Horizon BCBSNJ through Caremark.

For each 30-day supply of prescription medication obtained at a retail pharmacy, participants pay a copayment based on whether the prescription is for generic drugs or for brand name drugs. You may pur-

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chase up to a 90-day supply of medication at a pharmacy when prescribed by your provider, by paying the applicable copayments (31- to 60-day supply — two copayments, 61- to 90-day supply — three copayments).

A mail order program is also available. When mail order is used, you may obtain up to a 90-day supply of medication for a single copayment.

For more information about the Employee Prescription Drug Plan, see the *Employee Prescription Drug Plan Member Handbook* which is available from your employer, by contacting the Division of Pensions and Benefits, or online at: www.state.nj.us/treasury/pensions.shbp.htm

Retiree Prescription Drug Plan

Retirees are not eligible for the Employee Prescription Drug Plan. Prescription drug benefits for retirees covered under Chapter 172 are **provided through NJ DIRECT15**.

Retirees enrolled in NJ DIRECT15 have a prescription drug card program with a three-tier copayment design.

The following copayment amounts are applied to prescriptions purchased through the NJ DIRECT Retiree Prescription Drug Plan.

Retail Pharmacy — up to a 90-day supply copayment amounts (for 2009)			
Supply	Generic	Preferred Brand	All Other Brand
01-30 days	\$8	\$17	\$34
31-60 days	\$16	\$34	\$68
61-90 days	\$24	\$51	\$102

SHBP Retired Mail Order — up to a 90-day supply copayment amounts (for 2009)			
Supply	Generic	Preferred Brand	All Other Brand
01-90 days	\$9	\$27	\$45

SEHBP Retired Mail Order — up to a 90-day supply copayment amounts (for 2009)			
Supply	Generic	Preferred Brand	All Other Brand
01-90 days	\$8	\$25	\$42

There is a \$1,082 annual maximum in prescription drug copayments per person in 2009. Once a person has paid \$1,082 in copayments in a calendar year, that person is no longer required to pay any prescription drug copayments for the remainder of that calendar year. Prescription drug copayments are not eligible for reimbursement and do not apply to NJ DIRECT15 out-of-network deductible or coinsurance amounts.

The Retiree Prescription Drug Plan is administered by CVS/Caremark. In the event a pharmacy does not participate with CVS/Caremark, you should pay for the prescription and file a claim with CVS/Caremark. You can obtain a claim form from the Division's Web site at www.state.nj.us/treasury/pensions or contact CVS/Caremark at 1-800-929-2524 or on the Web at www.caremark.com

This fact sheet has been produced and distributed by:
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This fact sheet is a summary and not intended to provide total information.
 Although every attempt at accuracy is made, it cannot be guaranteed.

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NJ DIRECT15 COVERAGE AVAILABLE UNDER CHAPTER 172 (for plan year 2009) 1-800-414-SHBP (1-800-414-7427) www.horizonblue.com/shbp		
PLAN NAME	IN-NETWORK	OUT-OF-NETWORK¹
SERVICE AREAS	Nationwide	Nationwide
PRIMARY AND PREVENTATIVE CARE		
PHYSICIAN (OFFICE VISITS)	100% after \$15 copayment per visit	70% after deductible; no coverage for wellness care
ANNUAL ROUTINE PHYSICAL EXAMS	100% after \$15 copayment per visit	Not covered
ROUTINE CHILD AND WELL-BABY CARE	100% after \$15 copayment per visit	Not covered
IMMUNIZATIONS (EXCEPT FOR TRAVEL AND/OR JOB RELATED)	100% after \$15 copayment per visit	Not covered except for children under 12 months, 70% after deductible
ANNUAL ROUTINE GYNECOLOGICAL EXAMS	100% after \$15 copayment per visit	70% after deductible
ANNUAL ROUTINE MAMMOGRAM (ONE ANNUAL MAMMOGRAM FOR WOMEN AGE 40 AND OVER)	100% no copayment	70% after deductible
PROSTATE SCREENING (ONE ANNUAL PROSTATE SCREENING FOR MEN AGE 40 AND OVER)	100% after \$15 copayment per visit	Not covered
ANNUAL ROUTINE EYE EXAMINATIONS	100% after \$15 copayment per visit	Not covered
HEARING AIDS	Not covered	Not covered

¹Benefits, excluding hospital expenses, are based on the Horizon BCBS discounted provider allowance or the "reasonable and customary" fee schedule at the 90% percentile.

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PLAN NAME	IN-NETWORK	OUT-OF-NETWORK¹
SPECIALIST OFFICE VISITS	100% after \$15 copayment per visit	70% after deductible; no coverage for wellness care
ALLERGY TESTING	100% after \$15 copayment per visit	70% after deductible
ALLERGY TREATMENT ROUTINE INJECTIONS	100% after \$15 copayment per visit	70% after deductible
PRENATAL CARE/ MATERNITY CARE	\$15 copayment for first prenatal office visit then 100% covered. Precious Additions - a voluntary prenatal education program	70% after deductible
INFERTILITY SERVICES (MUST BE PRE-CERTIFIED)	Diagnosis covered after \$15 copayment; treatment covered with limitations after \$15 copayment	Diagnosis covered at 70% after deductible; treatment covered with limitations at 70% after deductible
OUTPATIENT FACILITY VISITS		
CHEMOTHERAPY	100%; no copayment	70% after deductible
RADIATION THERAPY	100%; no copayment	70% after deductible
INFUSION THERAPY	100% after \$15 copayment per visit	70% after deductible
X-RAYS AND LAB TESTS (OUTPATIENT)	100%; no copayment	70% after deductible
SPECIALTY AND OUTPATIENT CARE		
OUTPATIENT THERAPY (SPEECH,² OCCUPATIONAL, PHYSICAL)	100% after \$15 copayment per visit	70% after deductible

¹Benefits, excluding hospital expenses, are based on the Horizon BCBS discounted provider allowance or the "reasonable and customary" fee schedule at the 90% percentile.

²Speech therapy limited to restoration after a loss or impairment of a demonstrated previous ability to speak. To develop or improve speech after surgical correction of a birth defect.

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PLAN NAME	IN-NETWORK	OUT-OF-NETWORK¹
OUTPATIENT CARDIAC REHABILITATION THERAPY	100% after \$15 copayment per visit	70% after deductible
CHIROPRACTIC CARE	100% after \$15 copayment per visit; limit of 30 visits per calendar year combined in-network and out-of-network	70% after deductible for up to 30 visits per calendar year combined in-network and out-of-network
HOME HEALTH CARE	Services and supplies covered at 100% with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered	Services and supplies covered at 70% after deductible with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered
HOSPICE CARE (OUTPATIENT)	100%; no copayment	70% after deductible
DURABLE MEDICAL EQUIPMENT (DME)	90%; no copayment	70% after deductible
PROSTHETIC DEVICES (MUST BE APPROVED IN ADVANCE)	90%; no copayment	70% after deductible
INPATIENT SERVICES		
HOSPITAL (ROOM AND BOARD AND OTHER INPATIENT SERVICES)	100%; no copayment	70% after separate \$200 deductible per hospital stay
SKILLED NURSING FACILITIES	100%; no copayment; for up to 120 days per calendar year; combined in-network and out-of-network	70% after deductible; for up to 60 days per calendar year; combined in-network and out-of-network
HOSPICE FACILITY	100%; no copayment	70% after deductible
INPATIENT VISITS	100%; no copayment	70% after deductible

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PLAN NAME	IN-NETWORK	OUT-OF-NETWORK¹
INPATIENT SURGERY	100%; no copayment	70% after deductible
OUTPATIENT SURGERY	100%; no copayment	70% after deductible
MENTAL HEALTH		
INPATIENT TREATMENT³	100%; no copayment; up to 25 days per calendar year; balance at 90% up to annual and/or lifetime maximums	50 days per calendar year at 50% after deductible up to annual and/or lifetime maximums
OUTPATIENT TREATMENT³	90% up to annual and/or lifetime maximums	70% after deductible up to annual and/or lifetime maximums
ALCOHOL AND DRUG ABUSE		
INPATIENT TREATMENT	Same as any other illness	Same as any other illness
INPATIENT DETOXIFICATION	Same as any other illness	Same as any other illness
OUTPATIENT TREATMENT	100%; no copayment; no visit limit	70% after deductible
INPATIENT REHABILITATION	Same as any other illness	Same as any other illness
OUTPATIENT DETOXIFICATION	Same as any other illness	Same as any other illness

¹ Benefits, excluding hospital expenses, are based on the Horizon BCBS discounted provider allowance or the "reasonable and customary" fee schedule at the 90% percentile.

³ Biologically-based mental health conditions are treated like any other illness and not subject to annual or lifetime mental health dollar mental health dollar maximums or separate mental health visit limits.

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PLAN NAME	IN-NETWORK	OUT-OF-NETWORK¹
EMERGENCY CARE		
HOSPITAL EMERGENCY ROOM (COPAYMENT WAIVED IF ADMITTED)	100% after \$50 copayment	100% after \$50 copayment
AMBULANCE (FOR EMERGENCY TRANSPORTATION ONLY)	90%; no copayment	70% after deductible
VOLUNTARY PROGRAMS		
DISEASE MANAGEMENT PROGRAMS⁴	Asthma, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Diabetes, Heart Failure, Hepatitis C, Obesity, and Multiple Sclerosis	Asthma, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Diabetes, Heart Failure, Hepatitis C, Obesity, and Multiple Sclerosis
PLAN DEDUCTIBLES, OUT-OF-POCKET MAXIMUMS, AND ANNUAL/LIFETIME BENEFIT MAXIMUMS		
DEDUCTIBLES (INDIVIDUAL)	None	\$100 per calendar year; \$200 per hospital admission
DEDUCTIBLES (FAMILY MAXIMUM)	None	\$250 per family, per calendar year; \$200 per hospital admission
MAXIMUM OUT-OF-POCKET (INDIVIDUAL)	\$400 per calendar year (coinsurance only)	\$2,000 per calendar year (coinsurance only)
MAXIMUM OUT-OF-POCKET (FAMILY)	\$1,000 per calendar year (coinsurance only)	\$5,000 per calendar year (coinsurance only)
MAXIMUM PLAN COVERED EXPENSES ANNUAL/LIFETIME	Unlimited ⁵	\$1,000,000 lifetime ⁵

¹Benefits, excluding hospital expenses, are based on the Horizon BCBS discounted provider allowance or the "reasonable and customary" fee schedule at the 90% percentile.

⁴Most disease management programs provide educational materials, and in some cases, individualized case management for members with an emphasis on health education and behavior modification.

⁵Mental Health Maximums: \$15,000 annual; \$50,000 lifetime. Up to 2,000 restoration feature each year with a lifetime maximum of \$50,000. Biologically-based mental health conditions are treated like any other illness and not subject to annual or lifetime mental health dollar mental health dollar maximums or separate mental health visit limits.