



Employers' Pensions and Benefits Administration Manual

For the State Health Benefits Program (SHBP)
and the School Employees' Health Benefits Program (SEHBP)

SHBP & SEHBP

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**THE STATE HEALTH BENEFITS PROGRAM
(SHBP) AND THE SCHOOL EMPLOYEES'
HEALTH
BENEFITS PROGRAM (SEHBP)**

The State Health Benefits Program (SHBP) offers medical, prescription drug, and dental coverage to qualified State and local government public employees, retirees, and eligible dependents. Local employers must adopt a resolution to participate in the SHBP.

The State Health Benefits Commission (SHBC) is the executive organization responsible for overseeing the SHBP.

The State Health Benefits Program Act is found in the New Jersey Statutes Annotated, Title 52, Article 14-17.25 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

The School Employees' Health Benefits Program (SEHBP) offers medical, prescription drug, and dental coverage to qualified local education public employees, retirees, and eligible dependents. Local education employers must adopt a resolution to participate in the SEHBP.

The School Employees' Health Benefits Commission (SEHBC) is the executive organization responsible for overseeing the SEHBP.

The School Employees' Health Benefits Program Act is found in the New Jersey Statutes Annotated, Title 52, Article 14-17.46 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

The New Jersey Division of Pensions & Benefits (NJDPB), specifically the Health Benefits Bureau and the Bureau of Policy and Planning, are responsible for the daily administrative activities of the SHBP and the SEHBP.

SHBP AND SEHBP COMPONENT PLANS

All SHBP/SEHBP plans are self-funded, which means that the money paid out for benefits comes directly from a SHBP/SEHBP fund supplied by the State, participating local employers, and member premiums.

PLAN CHOICE

The availability of plans offered to eligible employees may be limited by local employers through the binding collective bargaining process. However, local employers must offer at least one plan from each category of plans.

The local employer may, through its sole discretion, impose the provisions of a binding collective bargaining agreement on those employees who have no majority representation for collective bargaining purposes. The local employer may, through the collective bargaining process, offer employees all, a combination of plans, or one plan from each category of plans. The plans offered may be different for each bargaining group.

State employees cannot participate in NJ DIRECT10.

Resolution to Limit the Selection of Medical Plans

Local government and local education employers may adopt a resolution to limit the medical plans offered through the SHBP or SEHBP.

Employee Contribution Required

Under P.L. 2011, c. 78 (Chapter 78), employees are required to contribute toward their health benefits premiums. The amount that the employee must contribute is based on a specified salary range. As previously required under P.L. 2010, c. 2 (Chapter 2), the employee contribution cannot be less than 1.5 percent of the member's salary.

State employees contribute at the full amount of the required contribution rate.

For local government and local education employees employed as of the contribution's effective date (June 28, 2011), the percentage of premium requirement is implemented in a four-year phase-in at contribution levels of 1/4, 1/2, 3/4, and the full amount of the contribution rate during the phase-in years. The first year phase-in begins upon the expiration of the collective negotiations agreement in effect as of June 28, 2011.

For new employees hired on or after June 28, 2011, or after the expiration of a collective negotiations agreement that was in force on June 28, 2011, the employees contribute (without any phase-in) at the full amount of the required contribution rate.

Calculation charts and worksheets reflecting the phase-in of contribution levels for employees employed on the contribution's effective date who will pay 1/4, 1/2, 3/4, and the full amount of the contribution rate during the phase-in years can be found on the NJDPB website:

www.state.nj.us/treasury/pensions

WAIVERS OF COVERAGE

**Waiver for State Monthly,
State Biweekly Employees**

State employees are permitted to waive their SHBP medical and prescription coverage provided they have other health care coverage of their own or as a dependent. State employees who waive coverage can thereby avoid the contribution of a percentage of the premiums for health and/or prescription drug coverage required under Chapter 78.

There is no additional annual payment, or incentive, to State employees who waive SHBP medical and prescription coverage.

Waiver of SHBP medical and prescription coverage must be submitted online through Benefitsolver. In order to reinstate coverage under the SHBP, the member must apply online through Benefitsolver within 60

days of the loss of the other coverage as well as provide proof of loss of that coverage. Reinstatement will be effective immediately following the loss of the employee's other health plan coverage.

Waiver for Local Government/Education Employers

Local government/education employers that participate in the SHBP/SEHBP may permit an employee to waive the health benefits coverage offered by the employer (local government/education employer), if the employee is eligible for any other employer provided health care coverage of their own or as a covered dependent.

The local government/education employer may pay the employee an annual incentive to waive SHBP/SEHBP coverage. The incentive cannot be more than 25 percent of the amount saved by the local government/education employer or \$5,000, whichever is less. The employing local government/education location establishes what the annual amount payable to an employee choosing to waive the health benefits coverage will be. **Note:** Employees who waive their SHBP/SEHBP benefits for other coverage are not eligible for a waiver incentive if their other coverage is with the SHBP or SEHBP.

The decision of the local government/education employer to allow its employees to waive coverage, and the amount of the incentive to be paid, cannot be subject to the collective bargaining process.

An employee who has waived coverage under the provisions of this law may immediately resume health coverage under his or her employer's health plan in the event that the other health care coverage is terminated, provided the member applies for enrollment online through Benefitsolver within 60 days of the loss of the other coverage and provides proof of loss of that coverage.

Note: Any local government/education employer contemplating exercising its right to offer a cash incentive to

waive health benefits should discuss the federal income tax consequences of such an action on its employees with legal counsel knowledgeable in federal and State tax matters, especially with regard to employee benefits plans. If a cash incentive provided by an employer is not part of an IRC Section 125 plan, the health benefits provided to its other employees may be subject to federal taxes.

HEALTH PLAN ADMINISTRATORS

All plans are administered for the SHBP/SEHBP by Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ).

TYPES OF PLANS CURRENTLY OFFERED

Preferred Provider Organization (PPO)

The Preferred Provider Organization (PPO) plans are available nationwide. Members are not required to choose a primary care physician and do not need a referral for in-network services under the plans.

In-Network Benefits

When a member sees a physician who participates in-network, the member will only pay the appropriate copayment for eligible services.

If the physician does not participate in the network, the services will be considered out-of-network.

Members should contact their doctor to see if he or she participates in the network. For specific details on in-network services, members should contact their plan.

Out-Of-Network Benefits

Out-of-network benefits allow members to utilize any licensed provider, but a claim form must be filed. Most eligible out-of-network care is reimbursed at the applicable percentage of reasonable and customary allowances after a member's annual deductible is met.

Out-of-network hospital admissions are also subject to a deductible. For specific details on out-of-network benefits, members should contact their plan.

Under out-of-network benefits, your out-of-pocket expenses may substantially increase because you will be charged for any portion of the fee that is above the reasonable and customary amount allowed by the plan for payment to a provider for a particular service.

For example, if a provider's charge for a surgical procedure is \$500 and the reasonable and customary allowance is \$400, you are responsible for the \$100 difference in addition to any coinsurance and deductible amounts.

Health Maintenance Organization Plans (HMO)

HMO plans have networks that provide services nationwide. HMO plans require copayments for routine services such as office visits, use of emergency rooms, etc.

Members who enroll in an HMO must select a Primary Care Physician (PCP) from a group of participating providers contracted by the HMO. All services, except emergencies, are coordinated through the chosen PCP.

The member's PCP will refer the member to a specialist who participates in the HMO network when a specialist's care is required. HMOs offer electronic referrals which facilitate the use of specialists.

HMOs have no deductibles or claim forms to file, but members are required to pay a copayment for visits to their PCP or a referred specialist.

For specific details on HMO plan benefits, members should contact their plan.

Tiered-Network Health Plans

Tiered plans use a two-tiered network of participating providers. Members are not required to choose a PCP,

and referrals for specialists are not required. The plan provides no out-of-network coverage. Members utilizing Tier 1 providers will have lower out-of-pocket expenses.

High Deductible Health Plans

The SHBP/SEHBP High Deductible Health Plans (HDHP) combine medical benefits that include prescription drugs, with a tax-advantaged Health Savings Account (HSA).

Under a HDHP, members must pay an annual deductible before the medical plan pays for any covered health care costs. Only services that are covered by the plan count toward the annual deductible. Eligible preventive services are normally covered at 100 percent and are not subject to the deductible.

Once the entire annual deductible is met, members pay a percentage of the covered health care costs (coinsurance) and the health plan pays the rest — up to any out-of-pocket maximum.

The HSA is a pre-tax personal savings account funded by the member (and employer for the HDHP 1500 plans). HSA funds may be used to pay for qualified medical expenses not covered through the health plan including deductibles, coinsurance, dental or vision care, and other costs as outlined by the IRS.

HDHPs are not offered to SEHBP active employees.

PRESCRIPTION DRUG PLANS

The SHBP/SEHBP Prescription Drug Plans are offered to eligible, active State employees and their dependents as a separate drug plan. Local employers may also elect to provide the SHBP/SEHBP Prescription Drug Plans to their employees as a separate prescription drug benefit. The Prescription Drug Plans are administered for the SHBP and SEHBP by OptumRx, the pharmacy benefit manager for all eligible members.

For specific details about the Prescription Drug Plans, see the *Prescription Drug Plans Member Guidebook*. Additional information is also available in the *Summary Program Description*.

THE SHBP EMPLOYEE DENTAL PLANS

The SHBP Employee Dental Plans are available to eligible 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 program provides a choice between two different types of plans, the Dental Expense Plan and Dental Provider Organizations (DPOs). A comparison of the types of plans is found in the *Dental Plans — Active Employees Fact Sheet*. More detailed information is available in the *Employee Dental Plans Member Guidebook*.

Eligible full-time employees and their eligible dependents must apply for dental coverage online through Benefitsolver.

Dental Plan Organizations (DPOs)

DPOs are individual companies offering dental services through contracts with a network of dental providers. A DPO member selects a DPO dentist, and the cost of most diagnostic and preventive services is covered in full, although certain services require an additional co-payment. The DPOs operate much like HMOs in that they will not cover services provided by an out-of-network provider unless there was a proper referral. You must use a dentist who is a member of the DPO you selected or be referred by your DPO dentist.

Dental Expense Plan

The Dental Expense Plan is a traditional indemnity plan that allows a member to obtain services from any den-

tist. After the member satisfies a deductible, the member is reimbursed for a percentage of the reasonable and customary charges for the services that are covered under the plan. The Dental Expense Plan has a network of participating providers who offer discounted services. Employees save money by using these participating providers. This plan is administered under a contract between the SHBC and Aetna Dental.

The cost of participation in either plan is shared equally by the State and the employee. Premium payments are made through payroll deductions.

EMPLOYER PARTICIPATION

Employer Enrollment in the SHBP/SEHBP

The SHBP/SEHBP is open to all local government employers who elect to participate by completing the *Resolution to Authorize Participation in the SHBP/SEHBP*.

Employers can enroll in the medical plan only or medical plan and prescription drug program. However, an employer enrolling only in the medical plan must offer a uniform, stand-alone prescription drug plan to all eligible employees in order to be in compliance with the SHBP/SEHBP.

To enroll in the SHBP/SEHBP, the employer must submit a completed resolution a minimum of 75 days for employers with fewer than 250 employees, and 90 days for employers with 250 or more employees prior to the desired entry date. The effective date of coverage for employers with fewer than 250 employees, Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 participants, and retired members will be the first day of the month following a period beginning 75 days after the receipt by the SHBC or SEHBC of the completed resolution. The effective date of coverage for employers with 250 or more employees, COBRA participants, and retired members will be the first day of the

month following a period beginning 90 days after the receipt by the SHBC/SEHBC of the completed resolution.

You can obtain the resolution and enrollment packet by calling the Office of Client Services at (609) 292-7524. This packet will include:

- *Resolution to Authorize Participation in the SHBP/SEHBP*
- *Resolution to Elect a Premium Delay Option*
- Current Rate Charts
- *Resolution to Adopt the Provisions of P.L. 1999, c.48 (Chapter 48)*

These resolutions must be completed by the location's Certifying Officer and returned to the Health Benefits Bureau a minimum of 60 days prior to the effective date of coverage. Submission of the resolutions at least 75 – 90 days ahead of the effective date will ensure that sufficient time is available to process all applications from the employer's employees, retirees, and COBRA participants.

Employer Participation in the SHBP/SEHBP Employee Dental Plans

Local government or education employers wishing to initiate participation should submit a *Resolution for SHBP or SEHBP Dental Plan Participation* to the NJDPB.

The resolution must be completed by the location's Certifying Officer and returned to the Health Benefits Bureau a minimum of 75 days for employers with fewer than 250 employees, and 90 days for employers with 250 or more employees prior to the desired entry date. The effective date of coverage for employers with fewer than 250 employees, COBRA participants, and retired members will be the first day of the month following a period beginning 75 days after the receipt by the SHBC of the completed resolution. The effective date of coverage for employers with 250 or more employees, CO-

BRA participants, and retired members will be the first day of the month following a period beginning 90 days after the receipt by the SHBC of the completed resolution. Submission of the resolutions at least 75 – 90 days ahead of the effective date will ensure that sufficient time is available to process all applications from the employer's employees, retirees, and COBRA participants.

TERMINATION OF EMPLOYER PARTICIPATION

Voluntary Termination

When an employer chooses to terminate all participation in the SHBP/SEHBP, a completed *Resolution to Terminate Participation in the SHBP/SEHBP* must be submitted by the employer to the SHBC or SEHBC for approval. If an employer chooses to terminate participation in the prescription drug plan only, a completed *Resolution to Terminate Prescription Drug Participation* must be submitted by the employer to the SHBC or SEHBC for approval. A minimum of 60 days notice (preferably 75 or more days) is required in order to effect the termination process. When an employer terminates participation, the coverage of all its employees, retirees, and COBRA participants is also terminated unless the retirees are covered by specific legislation that permits them to continue SHBP/SEHBP participation upon the termination of their former employer.

An employer choosing to terminate participation in the Employee Dental Plans must submit a completed *Resolution for SHBP/SEHBP Dental Plan Termination* to the SHBC for approval. A minimum of 60 days notice (preferably 75 or more days) is required in order to effect the termination process.

Termination for Nonpayment

A participating employer will be considered in default if premiums are not paid within 31 days of the date they are due. At that point, coverage will terminate for all employees and dependents. When an employer defaults on payment, the NJDPB notifies the Office of the Attorney General and the Division of Local Government or the Department of Education, as appropriate, that the employer has failed to meet its obligations to the State of New Jersey. When the coverage is terminated, the employer must notify all employees and retirees of the termination of their coverage. Premiums will continue to accumulate with interest penalties.

ENROLLING ELIGIBLE EMPLOYEES

The employer benefits representative should enroll eligible employees as soon as possible so that their coverage can be processed and the necessary information can be provided to the insurance carrier prior to the effective date of coverage. Generally, enrollment is effective approximately 60 days after the date of hire. The effective date of coverage for State biweekly employees is determined by the payroll schedule of Centralized Payroll, but will also be approximately 60 days after hire.

The four employer responsibilities in enrollment are:

1. To determine employee eligibility;
2. To ensure that the eligible employee applies for coverage online through Benefitsolver and provide assistance as needed;
3. To certify the online enrollment through Benefitsolver in a timely manner; and
4. To provide the new employee with written notification of the requirements of the federal COBRA and Health Insurance Portability and Accountability Act (HIPAA) of 1996 laws, and other federal health insurance requirements.

DETERMINE ELIGIBILITY

State Employees

To be eligible for coverage, a State employee must meet the actively at work requirements, and work full-time or be an appointed or elected officer of the State of New Jersey.

For State employees, full-time means the normal full-time weekly schedule for the particular title held; 35 hours per week is the minimum requirement for full-time status.

Any newly appointed or elected official is required to work a minimum of 35 hours per week to be considered full-time and eligible for coverage under the SHBP.

Under Chapter 172, certain part-time employees of the State of New Jersey, and part-time faculty members at New Jersey public institutions of higher education (State colleges, State Universities, and county community colleges), who are members of a State-administered retirement system, are eligible for enrollment for coverage in the SHBP.

Certain State intermittent employees are also eligible for SHBP coverage (see below).

Local Employees

Note: Local Employers should also see the "Employer Shared Responsibility Provisions in the ACA" section.

To be eligible for local employer SHBP/SEHBP coverage, a local employee must appear on regular payroll and work full-time or be an appointed or elected officer receiving a salary.

In order for an employee of a local employer hired after May 21, 2010, to be eligible for coverage under the SHBP/SEHBP, he or she will be required to work a minimum number of hours per week as determined by reso-

lution of the governing body of the local employer, but in no instance will the minimum hours be less than 25.

Certain part-time local employees — part-time faculty members at New Jersey county community colleges — are now eligible for SHBP/SEHBP coverage (see below).

Any employee or officer of the local employer or the State who met the minimum work hour requirements prior to May 21, 2010, will be eligible for continued coverage under the SHBP/SEHBP provided there is no break in the employee's service or reduction in work hours.

Resolution to establish the number of hours constituting full-time status.

Full-time also means employment for 12 months per year, except in the case of employees whose regular and normal work schedule is contractually established at 10 months per year.

Appointed or Elected Officials: An appointed or elected officer of a local employer who is compensated on a fee basis as the method of payment of wages or salary, but who is not a self-employed independent contractor compensated on a fee basis, may also be eligible for local employee coverage. To qualify for coverage as an appointed officer, a person must be appointed to an office specifically established by law, ordinance, resolution, or another official action required by law as a method of establishing a public office by an appointing authority.

Any newly appointed or elected official is required to work a minimum of 35 hours per week to be considered full-time and eligible for coverage under the SHBP/SEHBP.

An individual appointed under a general authorization, that is, the specific office to which the person is appointed has not been established by law, ordinance, resolution, or another official action required by law to

establish a public office by an appointing authority, is not eligible to participate in the program as an appointed officer. An officer appointed under a general authorization must qualify for participation in the SHBP/SEHBP as a full-time employee.

Medical Plan Coverage for Part-Time Employees

P.L. 2003, c. 172 (Chapter 172) extends eligibility for enrollment for coverage in the SHBP/SEHBP to some part-time employees of the State of New Jersey and part-time faculty members employed at New Jersey public institutions of higher education (New Jersey State colleges, State Universities, or county community colleges), as long as they are members of a State-administered retirement system.

Part-time employees of the Palisades Interstate Parkway Commission, the New Jersey Building Authority, and the New Jersey Commerce and Economic Growth Commission are also eligible.

Eligible part-time employees may enroll in a SHBP/SEHBP medical plan and corresponding Prescription Drug Plan, or a medical plan only, and must pay the full cost of coverage for the level of coverage selected. The SHBP/SEHBP determines whether an employee is eligible for coverage.

Part-time employees who enroll in the SHBP/SEHBP will be billed monthly for the cost of the coverage selected. There are separate rate charts listing the cost of this coverage.

Eligible employees must apply online through Benefitsolver to enroll in coverage. Otherwise, employers should follow the same steps for SHBP/SEHBP enrollment as for other employees eligible for SHBP/SEHBP coverage.

For more information about coverage for part-time employees, please see the *Health Benefits Coverage for Part-time Employees* Fact Sheet.

Medical Plan Coverage for Intermittent State Employees

Certain intermittent State employees who have worked a minimum of 750 regular pay status hours within the previous fiscal year (i.e., July to June) are eligible for enrollment in medical and/or prescription drug plans available to full-time employees. Intermittent employees who maintain 750 hours of work per fiscal year will receive coverage for the next fiscal year (at least through the period covered by the labor contract in effect).

Intermittent State employees who meet the minimum pay status hours outlined above must also be covered under the labor contract between the CWA and the State of New Jersey that committed the State to provide SHBP coverage to intermittent employees.

Employers must certify that their intermittent employees have at least 750 regular pay status hours in the prior fiscal year to qualify for coverage in subsequent years. The Human Resource Offices of the Department of Labor, the Department of Environmental Protection, and the Department of the Treasury will re-certify eligibility of every intermittent employee with SHBP coverage each year.

Medical Plan Coverage for National Guard Members Called to State Active Duty

National Guard members who are called to State active duty for 30 days or more, and their eligible dependents, are eligible for enrollment in an SHBP medical plan and the Employee Prescription Drug Plan at the State's expense less the contribution required of all State employees (see the "Employee Contribution Required" section). The Department of Military and Veteran's Affairs is

responsible for notifying eligible members and for notifying the NJDPB of members who are eligible.

Sabbaticals, Approved Leaves of Absence, and Multiple Public Positions

A State or local employee who is on sabbatical or an approved leave of absence will have full-time status and be eligible for coverage if the compensation paid is 50 percent or more of the salary granted just prior to the leave and the period of eligibility terminates with the end of the fiscal year.

An employee holding multiple public positions at the same time will be considered full-time if the employee satisfies the definition of full-time in any one of the positions he or she holds.

State and Local Employee Ineligibility for SHBP/SEHBP Coverage

State and local employees who are ineligible for coverage include:

- Those who have less than two months of continuous service;
- Those who are employed on a short-term, seasonal, intermittent or emergency basis;
- Those who are paid an hourly rate; and
- Those who are not on payroll.

State statute specifically prohibits two members who are each enrolled in the SHBP/SEHBP plans from covering each other. Therefore, an eligible individual may only enroll in the SHBP/SEHBP as an employee or retiree, or be covered as a dependent.

Eligible children may only be covered by one participating subscriber. For example, a husband and wife both have coverage based on their employment and have children eligible for coverage. One may choose Family

coverage, while the spouse waives coverage through his/her employment; or one may choose Single coverage while the spouse chooses Parent and Child(ren) coverage.

New Jersey State Legislators and SHBP Coverage

P.L. 2003, c. 308 (Chapter 308) prohibits members of the State Legislature who elect health coverage from their legislative position from having primary health insurance coverage from another public employer.

Chapter 308 applies to members of the State Legislature who are at the same time employed by or become employed with another public employer in New Jersey that provides health benefits coverage. In such cases, the member must waive his or her health coverage from the other public employment in order to retain the health coverage through employment in the State Legislature; or, the member may waive health benefits coverage through the legislative position and accept primary coverage from the other public employer.

Employer Shared Responsibility Provisions in the ACA

Pursuant to the Employer Shared Responsibility Provisions in the federal Affordable Care Act (ACA), effective January 1, 2015, applicable large employers (defined as those with at least 50 full-time or full-time equivalent employees) may face a penalty if they do not offer their full-time employees the opportunity to enroll in health care coverage that meets a standard of affordability and provides the employee with minimum value.

To determine whether employers are in compliance with the Employer Shared Responsibility Provisions, and to calculate and assess Employer Shared Responsibility Payments for employers who are not in compliance, the Internal Revenue Service (IRS) will require employers to file yearly returns under sections 6055 and 6056 of

the Internal Revenue Code (IRC). These returns will require employers to provide information on their full-time employees as well as the standards and conditions of any health coverage offered by the employer.

Local Employer as an Applicable Large Employer

For the purposes of determining whether an employer qualifies as an applicable large employer subject to the Employer Shared Responsibility Provisions in the ACA, employers must add the total number of their full-time employees to the total number of their full-time equivalent employees. The IRS defines a full-time employee as those who average 30 or more hours of work per week. This determination is generally made during a look-back period that the employer chooses to use. IRS regulations require all applicable employers to report any employee who meets their definition of full-time.

In addition to reporting on employment status, the IRS also requires reporting on the health coverage offered to full-time employees. To assist with reporting, Local Employers have been provided with a data file that contains information on employees who had coverage under the SHBP/SEHBP, along with all covered dependents. The data file is available for all SHBP/SEHBP participating Local Employers to view on EPIC. Instructions for viewing the data file may be found at: www.nj.gov/treasury/pensions

PROVIDE EMPLOYEE WITH ONLINE ACCESS TO BENEFITSOLVER

Eligible employees must submit coverage elections through Benefitsolver. Failure to do so or neglecting to add an eligible family member when first becoming eligible for coverage will delay enrollment until the next Open Enrollment period.

Enrollment of Eligible Dependents

Enrollment of dependents normally occurs in one of three situations: when the employee initially enrolls; within 60 days of becoming a dependent (or 90 days for a newborn dependent); or within 60 days of the dependent's loss of other coverage. If the employee fails to enroll a dependent when first eligible, then the employee will have to wait until the annual Open Enrollment period to add them to coverage.

An employee's eligible dependents are his or her spouse, domestic partner, or civil union partner, and children. An eligible dependent child is a natural, step-, adopted, or foster child under age 26 regardless of the child's marital, student, or financial dependency status. Documentation proving dependent eligibility must be submitted along with the application in order for the dependent to be enrolled. A list of acceptable documentation is included with each application.

Please note that under the provisions of P.L. 2005, c. 375 (Chapter 375), as amended by c. 38 (Chapter 38), certain over age children may be eligible for coverage until age 31. For information about continuing Health Benefits coverage for over age children until age 31, please see the NJDPB website.

SHBP/SEHBP Benefits Under the Civil Union Law

P.L. 2006, c. 103 (Chapter 103) establishes New Jersey Civil Unions. For more information about this legislation, see the *Civil Unions and Domestic Partnerships* Fact Sheet.

SHBP/SEHBP Benefits Under the Domestic Partnership Act

Under the New Jersey Domestic Partnership Act, SHBP benefits are extended to eligible same-sex domestic partners of State employees and retirees. Local public

employers participating in the SHBP/SEHBP are permitted to extend benefits to their employees and retirees through resolution or ordinance. There are certain conditions that must be met in order for the domestic partner of an enrolled member to be eligible for SHBP/SEHBP coverage.

SHBP/SEHBP members must be made aware of the possible federal tax implications of covering a domestic partner (see the *Civil Unions and Domestic Partnerships* Fact Sheet).

CERTIFY ENROLLMENT

Employers should check for completeness, accuracy, and any required attachments before certifying the health benefits enrollment through Benefitsolver.

Note: When completing the employer certification portion of the online enrollment for part-time faculty members eligible for coverage under Chapter 172, Certifying Officers of New Jersey State colleges, State Universities and county community colleges should use the same union code as for other adjunct faculty members.

EFFECTIVE DATES OF SHBP/SEHBP COVERAGE

There is a waiting period of approximately two months following an employee's date of hire before SHBP/SEHBP coverage becomes effective.

The timely online submission of the correct Health Benefits enrollment through Benefitsolver is very important, allowing the employee's coverage to start immediately following the two-month waiting period.

SHBP Coverage for State Employees

SHBP coverage for the State biweekly employee begins on the first day of the employee's fifth payroll period. The exact date of coverage for State biweekly employees will be determined by the payroll schedule issued

by the State's Centralized Payroll.

SHBP coverage for the State employee paid on a monthly basis begins on the first day following two months of employment. A State monthly employee who starts employment on May 14 will have a SHBP coverage effective date of July 14.

SHBP/SEHBP Coverage for Employees of Participating Local Employers

Coverage for the employee of a participating local employer begins on the first day following two months of employment. For example: if the employee starts work on June 14, SHBP/SEHBP begins on August 14 (assuming that the employee's properly completed and signed enrollment application has been submitted in a timely manner).

There are three exceptions to this effective date of coverage rule:

- If an employee had at least two months of service on the date the employer joins SHBP/SEHBP, coverage starts on the date the employer enters the program;
- If an employee has an annual contract, is paid on a 10-month basis, and begins work at the beginning of the contract year, coverage begins on September 1 (see below);
- If an employee was enrolled in the SHBP/SEHBP with a previous employer and the employee's coverage is still in effect on the day work begins with the current employer (COBRA coverage excluded), coverage begins immediately so there is no break in coverage.

SHBP/SEHBP Coverage Effective Dates for 10-Month Employees

For employees of local and State monthly employers

under a 10-month contract who begin employment at the start of the school year, coverage begins on the first of the month in which employment begins. In such cases, the two months preceding the first of the month in which the contract began are regarded as the two-month waiting period.

For example, a teacher who starts working for a school district at the beginning of the school year in September, under a 10-month contract, will have SHBP/SEHBP coverage effective as of September 1, with the preceding July and August regarded as the two-month waiting period.

For State biweekly employees working under a 10-month contract who begin employment at the start of the school year, SHBP coverage will begin on the first day of the pay period closest to September 1, with the four preceding pay periods regarded as the two-month waiting period.

TIMETABLE FOR ENROLLMENT IN THE SHBP/SEHBP FOR LOCAL AND STATE MONTHLY EMPLOYERS		
Date of Hire	Date Forms Must be Received at the NJDPB	Date Coverage Begins
January 1 – 31	February 5	March 1 – 31
February 1 – 28*	March 5	April 1 – 28**
March 1 – 31	April 5	May 1 – 31
April 1 – 30	May 5	June 1 – 30
May 1 – 31	June 5	July 1 – 31

*February 29 during leap years

**Since all months are not of equal length, there may be a difference in the "Date Coverage Begins" for certain employees. For example, if an employee began employment on July 31, coverage is not effective until the first day after completion of two full months. Months are calculated from date to date (i.e., Jan. 1 to Feb 1. constitutes one full month). If you have a question about a specific employee, contact the NJDPB, Health Benefits Bureau.

TIMETABLE FOR ENROLLMENT IN THE SHBP/SEHBP FOR LOCAL AND STATE MONTHLY EMPLOYERS		
Date of Hire	Date Forms Must be Received at the NJDPB	Date Coverage Begins
June 1 – 30	July 5	August 1 – 30
July 1 – 31	August 5	September 1 – October 1**
August 1 – 31	September 5	October 1 – 31
September 1 – 30	October 5	November 1 – 30
October 1 – 31	November 5	December 1 – 31
November 1 – 30	December 5	January 1 – 31
December 1 – 31	January 5	February 1 – March 1**

*February 29 during leap years

**Since all months are not of equal length, there may be a difference in the "Date Coverage Begins" for certain employees. For example, if an employee began employment on July 31, coverage is not effective until the first day after completion of two full months. Months are calculated from date to date (i.e., Jan. 1 to Feb 1. constitutes one full month). If you have a question about a specific employee, contact the NJDPB, Health Benefits Bureau.

SHBP/SEHBP Coverage Upon Termination of Employment, 10-Month Employees

For the purposes of both State and local employee coverage:

An employee paid under a 10-month contract that starts work at the beginning of the school year and terminates service with the employer at the end of that school year, will be entitled to a full year's coverage comparable to that of any employee paid on a 12-month basis, as long as the following is true: The employee has worked for the number of months prescribed by the contract or arrangement with the employer for that school year.

This means that SHBP/SEHBP coverage for 10-month

employees and their dependents will continue during the summer months subsequent to the end of the school year (July and August), provided that any contributions or premiums are made as required by the State or local employer.

For example, a teacher with a 10-month contract who begins employment at the start of the school year in September and then terminates employment on the last day of school in June will have coverage continue through the months of July and August immediately following the end of that school year.

Please note, however, that when the termination of employment at the end of the school year is because of the member's July 1 retirement, coverage under the active group ends August 1, at which time eligibility for coverage under the retired group becomes effective.

SHBP/SEHBP Coverage Upon Termination of Employment, 12-Month Employees

For the purpose of both local and State monthly employee coverage:

An employee who terminates employment will have their SHBP/SEHBP coverage terminated on the first of the following month. For example, an employee who terminates employment between January 1st and January 31st will have their coverage terminated February 1st.

Terminations and deletions must be completed via Benefitsolver, and will allow the employer to enter a termination retroactively up to one month.

Note: 10- or 12-month employees who retire on July 1st will have their coverage terminated on August 1st.

OPEN ENROLLMENT PERIODS

An annual Open Enrollment period is held for all eligible State employees and local participating employees. The Open Enrollment period is normally during the month of October; specific dates are announced in advance by

the Health Benefits Bureau.

Coverage changes made during the Open Enrollment period are effective the first biweekly payroll period of the new plan year for State employees paid through the State's Centralized Payroll Unit, and January 1 of the new plan year for all other State and local employees.

If making changes during Open Enrollment, completed health benefits enrollment must be submitted online through Benefitsolver by the deadline indicated in the Open Enrollment announcement materials.

The annual Open Enrollment period is the employee's opportunity to make changes to the coverage provided to themselves and any dependents. During the Open Enrollment period, employees may:

- Enroll in any of the medical, prescription, and/or dental plans offered for which the employee is eligible, if not previously enrolled;
- Change to another eligible medical or dental plan (dental plans require a minimum enrollment of 12 months);
- Add eligible dependents who have not previously enrolled (including over age children eligible under Chapter 375); and
- Delete dependents (this can also be done at any time during the year).

Special Open Enrollment Periods

Special Open Enrollment Periods are occasionally conducted because of changes that occur during the plan year that impact employees' coverage or cost. When these changes occur, the SHBP/SEHBP will authorize a special Open Enrollment.

Changes in Coverage and Family Status

Generally, active employees cannot change their plan, level of coverage, or dependent coverage until the next Open Enrollment period. There are exceptions when an employee may change coverage. These exceptions are:

- An employee who marries or enters into a civil union or same-sex domestic partnership may enroll their spouse/partner and/or newly-eligible dependent children. The change must be submitted online through Benefitsolver within 60 days of the marriage/partnership.
- When the birth or adoption of a child occurs, the dependent(s) must be enrolled online through Benefitsolver within 90 days of the birth or 60 days of the adoption. Adoption requires additional legal documentation to be included with the online submission.
- When a change in family status involving the loss of a family member occurs (divorce, death, loss of guardianship).
- The employee is on a leave of absence and cannot afford to pay for coverage. Coverage can be reduced from family to single or parent and child while employee is on the leave. When the employee returns to work, coverage can be increased back to family coverage.
- An employee's spouse/partner loses health benefit coverage; the employee has 60 days from the date of the loss of coverage to add a spouse/partner to his or her coverage online through Benefitsolver. The enrollment submission must be accompanied by the spouse/partner's proof of loss of other coverage showing the date coverage was lost.

For State monthly, local government, and education employees, coverage changes involving the addition of dependents are effective retroactively to the date of the

event of eligibility if the online enrollment through Benefitsolver is submitted within 60 or 90 days of the event. For State biweekly employees, coverage changes involving the addition of dependents are effective retroactive to the first day of the pay period in which the event occurred if the online enrollment through Benefitsolver is submitted within 60 or 90 days of the event. Active employees may decrease dependent coverage at any time. Deletions of dependent coverage are effective on a timely or prospective basis; that is, when they are processed through Benefitsolver.

EMPLOYER'S RESPONSIBILITIES UNDER LEAVES OF ABSENCE

The employer has responsibilities to:

- Advise employees of the status of their health benefits if they take a leave of absence.
- Let employees know that they may reduce coverage level (for financial reasons) while on leave and increase it again when they return.
- Provide employee and/or dependents with a specific COBRA Notice when a COBRA event occurs (see COBRA section on page 16).
- Maintain records that demonstrate your compliance with the COBRA law.
- Advise employees of the status of their health benefits when they return from a leave of absence.
- Provide Open Enrollment information to employees on a leave of absence.

Leave of Absence Without Pay for Illness

An employee can continue health coverage while on an approved leave of absence without pay for illness. State biweekly employee coverage will be provided by the State for the first six biweekly pay periods following the

last day the employee would normally be covered. Coverage may be obtained for an additional 20 biweekly pay periods provided the employee pays the full cost of the coverage.

State monthly employee coverage would be provided by the State for the first three months following the last day the employee would normally be covered. Coverage may be continued for an additional nine months provided the employee pays the full cost of the coverage. If an employer does not extend coverage for the three-month period, the employee may only elect to continue coverage for a maximum of nine months.

Local public employers may provide for payment of the first three months of approved sick leave with the employee being able to extend coverage by prepayment for an additional nine months. If the employer does not extend coverage for the three-month period, the employee may elect to continue coverage for a maximum of nine months only. The employer may not discriminate against any eligible employee or groups of employees.

Certain local educational agencies may agree to adopt the provisions of P.L. 1989, c. 127 (Chapter 127). Chapter 127 applies only to eligible employees of local boards of education, regional boards of education, county colleges, educational service commissions, jointure commissions, county special services school districts, county vocational-technical school districts, or any boards or commissions under the authority of the Commissioner of Education or State Board of Education.

Chapter 127 permits the employer to continue to pay for the coverage of an employee granted an approved leave of absence (with or without pay) for up to a two-year period, provided that the employee has worked for the location for at least three years. Contact the New Jersey Division of Pensions & Benefits, Health Benefits Bureau, P.O. Box 299, Trenton, NJ 08626-0299 to obtain a copy of the Chapter 127 resolution.

Leave of Absence Without Pay for Reasons Other Than Illness

An employee who is permitted to take an approved leave of absence for reasons other than illness, family leave, or furlough, may continue health coverage under the SHBP/SEHBP for up to nine months or 20 biweekly pay periods. The full cost of the coverage must be paid to the employer in advance. If the employee remains on leave beyond the time for which coverage has been purchased, then the Active Group coverage will terminate. The coverage may be extended under COBRA for a period not to exceed 18 months, including the total leave time. However, leave that qualifies under the Federal or State Family Leave Act is not deducted from the total COBRA eligibility period.

Family Leave

An employee who is taking family leave is entitled under the State Family Leave Act (NJFLA) to continue 12 weeks of health care coverage in any 24-month period at the expense of his or her employer while on family leave. This includes all health care benefits, including Prescription Drug, Dental, and Vision Care benefits if the employer provides them. State Family Leave is defined as leave from employment to provide care for the birth or adoption of a child, or the serious illness of a child, parent, or spouse.

The federal Family and Medical Leave Act (FMLA) has benefits similar to the State Family Leave Act with the exception that the federal act also requires that leaves of up to 12 weeks in any 12-month period be permitted for the employee's own serious illness.

Leave usually counts for both State and federal entitlements, except in the instance where an employee could be eligible for up to 24 weeks of leave in one year under certain circumstances. An employee could request a

leave for maternity and then childcare leave. The leave for maternity, which qualifies as personal illness, counts toward the FMLA. The employee would still be entitled to an additional 12 weeks under the NJFLA to care for the newborn child.

To be eligible for family leave, an employee must be employed for at least 12 months. Family leave can be taken on a continuous or intermittent basis, or by way of a reduced leave schedule under the conditions of the law.

In cases where the employee has a deduction, the employer must make arrangements with the employee on family leave to receive direct payment for the required employee contribution. If the NJDPB does not receive full payment from the employer, then the employee's benefit coverage will be terminated under the termination provisions of the SHBP/SEHBP.

The time an employee spends on federal or State family leave will not count as part of the COBRA eligibility period, should an employee receive approval from his or her employer to extend the leave.

Furlough

If an employee takes an approved furlough, the SHBP/SEHBP coverage will continue at the employer's expense. The employee must remit in advance the employee portion of premiums normally paid.

A State employee eligible for a voluntary furlough extension beyond the 30 days allowed will be treated as an exceptional case. The employee will have to pay the full cost of coverage for his or her extended furlough days in 10-day increments, or drop the coverage for the entire furlough extension benefit period(s) in which the employee takes a furlough day.

Workers' Compensation

An employee who has a Workers' Compensation award pending or has received an award of periodic benefits may have coverage continue and may continue the coverage of dependents. The employee must pay the employer, in advance, that portion of the premiums that would normally be paid.

Suspension

An employee who is suspended from employment is not eligible for benefits. If coverage is terminated as a result of suspension, the employee's only options for continuing group coverage are through COBRA or conversion to individual, direct payment coverage from his or her SHBP/SEHBP health plan carrier. See the *Summary Program Description* for a more extended discussion.

If the suspension is for gross misconduct, the employee will not be eligible for coverage through COBRA. Since the federal COBRA law does not precisely define gross misconduct, the employer should seek legal counsel before denying continuation of benefits through COBRA. (In light of this lack of precision in defining terms, some employers choose to simply offer continuation through COBRA regardless of the terms of termination.)

Employer's Responsibility for an Employee Who Returns From a Leave of Absence

The employer must advise an employee, upon returning from an approved leave of absence, as to the status of the health benefit coverage for the employee and eligible dependents.

- If coverage lapsed during the leave of absence, the employee must apply for reinstatement of health benefits coverage online through Benefitsolver (including prescription and dental coverage, if applicable). The employer must certify the date the employee returned to work.

- Coverage becomes effective on the date the employee returns to work if the employee is a State monthly or local employee. If the employee is a State biweekly, coverage will be effective on the first day of the pay period in which the employee returned to work.
- If an employee reduced coverage levels while on an approved leave, the employee may return to the former level of coverage upon returning to work by adding the dependent(s) back on to the coverage through Benefitsolver.
- If an employee is on leave during an Open Enrollment period, the employee may elect to make coverage changes upon returning to work. The employer must advise the employee that coverage elections must be submitted through Benefitsolver within 60 days of returning to work; the effective date of these changes will be the date the employee returned to work.
- If an employee's coverage was terminated during a leave, or the employee purchased COBRA coverage while on leave, the employee must enroll through Benefitsolver within 60 days of the first day the employee returns to work.

Return From Military Leave

An employee, upon returning from a military leave without pay, may enroll and receive appropriate coverage through Benefitsolver within 60 days after the date of return to active full-time employment. Any eligible dependents may also be included.

If a local group or State monthly employee applies for coverage within 60 days of returning from the military leave of absence, the coverage is effective on the first day of the month of return. Coverage for State biweekly employees is effective on the first day of the pay period of return.

In the event an eligible dependent of an employee is discharged from military service, the employee may enroll such dependent for appropriate coverage through Benefitsolver within 60 days of discharge. Coverage will be effective the date of return to dependency upon the employee.

Return From Suspension

When an employee returns from a suspension which was long enough to terminate coverage, the effective date for reinstatement would be the same as if the member returned from a leave of absence. If a court order or administrative ruling canceled the suspension and required the retroactive reinstatement of the employee's benefits, coverage will be reinstated retroactively, provided that a copy of the court order or ruling is submitted with the appropriate enrollment through Benefitsolver. The employee must pay the back his or her premium contribution share to the employer.

CHANGES IN STATUS

Part-Time Employment

When an employee changes from active full-time employment to part-time employment, the employee's coverage in the SHBP/SEHBP will be terminated, unless the employee is eligible for coverage under Chapter 172 (see the "Medical Plan Coverage for Part-Time Employees" section). Full-time status is defined as a minimum of 35 hours for State employees, or 32 hours for local government or education employees. If coverage is terminated, the employee may continue coverage under the COBRA program. Should employment resume to full-time status, the employee must reestablish eligibility for coverage and wait two months before coverage will become effective.

Dependent Eligibility

Dependent children are covered under their parent's enrollment until December 31 of the calendar year in which they reach age 26, at which time coverage will cease. The employee will be given notice that coverage is ending. Continued coverage beyond this termination is available in one of three ways:

1. Chapter 375 — Over Age Children until Age 31

Under Chapter 375, certain over age children may be eligible for coverage under the SHBP/SEHBP. This includes a child by blood or law who:

- is under the age of 31;
- unmarried;
- has no dependent(s) of his or her own;
- is a resident of New Jersey or is a full-time student at an accredited public or private institution of higher education; and
- 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.

The covered parent is responsible for the entire cost of dependent coverage under Chapter 375, and will be billed directly by the SHBP/SEHBP for the coverage cost. For more information, please see the *Health Benefits Coverage of Children until Age 31 under Chapter 375* Fact Sheet.

2. Over Age Dependent with Disabilities

A dependent child who is physically or mentally incapable of self-support at the end of the calendar year in which the child turns age 26. Coverage will continue while the child remains disabled, unmarried, and dependent upon the parent for support

and maintenance. If the parent's coverage is terminated, so is the child's.

The employee must submit an *Application for Continued Enrollment for Dependents with Disabilities*. This form is to be completed by the employee and the dependent's physician. This form must be submitted to the Health Benefits Bureau no later than January 31st of the year following the calendar year in which the child reaches age 26. This form is available on the NJDPB website. See the *Health Benefits Coverage Continuation for Overage Children with Disabilities* Fact Sheet for more information.

3. COBRA

Dependent children terminated at the end of the year in which they reach age 26 will be sent an offering to continue coverage through COBRA; the offering is required by federal law. Coverage may normally be extended for 36 months. Members should compare rates for Chapter 375 and COBRA, as they are both subject to change annually. However, if the child enrolls under Chapter 375 and loses coverage, he or she may not enroll under COBRA.

IDENTIFICATION CARDS

Identification cards for SHBP/SEHBP medical, prescription drug, and dental plans are issued from the carriers directly to the employees. These cards are mailed to the employee's home address, and should be carefully reviewed for accuracy. If the identification card has an error in the spelling of the name or ID number, advise the employee to contact the Office of Client Services. If there is an error in the listing of the Primary Care Physician or primary dentist, the employee should contact the insurance carrier directly. The contact number for each provider appears on the card itself.

PROVIDE WRITTEN NOTIFICATION OF FEDERAL COBRA AND HIPAA REQUIREMENTS

Under federal law, employers are required to notify all employees and dependents enrolling in their health plan of the provisions of the federal COBRA and HIPAA laws.

The COBRA and HIPAA notifications are intended to inform employees of their rights and obligations under these federal laws, and must be distributed to all new employees and their dependents enrolling in the SHBP/SEHBP within 90 days of enrollment. The initial COBRA notification and HIPAA notification must be addressed to the employee and dependents and mailed to the address furnished by the employee. The employer must keep a record of the notification. Please refer to the *COBRA – The Continuation of Health Benefits* Fact Sheet.

COBRA

Continuation of group coverage under COBRA is available if an employee or any covered dependents would otherwise lose coverage as a result of any of the following events:

- Termination of member's employment (except for gross misconduct);
- Employee's death;
- Employee's reduction in work hours;
- Employee's leave of absence;
- Divorce or legal separation from spouse (makes spouse ineligible for further active coverage);
- Termination of civil union partnership;
- Termination of eligible same-sex domestic partnership;
- Dependent child ineligibility; and
- Employee's election of Medicare as primary coverage.

Persons who lose coverage due to one of the reasons listed above are known as qualified beneficiaries.

Note: Employees eligible to enroll for coverage in SHBP or SEHBP at the time of retirement cannot enroll for health benefit coverage under COBRA.

The Cost of Coverage

If a qualified beneficiary (the person who loses coverage) chooses to purchase COBRA benefits, he or she will pay 100 percent of the cost of the coverage plus a two percent charge for administrative costs.

The cost of the qualified beneficiary's COBRA coverage depends not only on the plan (e.g., NJ DIRECT15, Horizon HMO, etc.) and the contract level (e.g., Single, Member and Spouse/Partner, etc.), but also on the employer's prescription drug coverage (either a freestanding prescription drug plan or prescription drugs included in the medical plan).

COBRA Forms and Rates

Businessolver is the COBRA Administrator and biller for the SHBP/SEHBP, and continuation of coverage elections must be submitted through Benefitsolver. The *COBRA Notice* is sent by Businessolver, and COBRA rate charts are available on the NJDPB website.

Duration of COBRA Coverage Following a COBRA Event

COBRA coverage may be purchased for up to 18 months if an eligible employee or eligible dependents (called COBRA subscribers or COBRA qualified beneficiaries) become eligible because of:

- Termination of employment;
- A reduction in hours; or
- A leave of absence.

Coverage may be extended up to 11 additional months, for a total of 29 months, if the COBRA subscriber has a Social Security Administration approved disability (under Title II or XVI of the Social Security Act) for a condition that existed when he or she enrolled in COBRA or began within the first 60 days of COBRA coverage. Coverage will cease either at the end of COBRA eligibility or when the subscriber obtains Medicare coverage, whichever comes first.

COBRA coverage may be purchased by a dependent for up to 36 months if he or she becomes eligible because of:

- Death;
- Divorce from spouse;
- Legal separation from spouse by the employee who participates in group coverage under an employer's plan;
- Dissolution of civil union partnership;
- Termination of eligible same-sex domestic partnership;
- Dependent attaining age 26 (unless coverage continues under Chapter 375); or
- The election of Medicare as primary coverage by the covered employee.

If a second qualifying event occurs during the 18-month period following the date of any employee's termination or reduction in hours, the beneficiary of that second qualifying event will be entitled to a total of 36 months of continued coverage. The period will be measured from the date of the loss of coverage caused by the first qualifying event.

Time spent on any leave other than federal or State Family Leave taken prior to COBRA enrollment must be subtracted from the COBRA eligibility period.

Example: An employee is out on a personal leave beyond nine months. Nine months of personal leave would be subtracted from the 18 months of COBRA eligibility leaving the COBRA subscriber with only nine months of COBRA eligibility.

Federal law requires that active employees terminate their employers' COBRA medical coverage if they choose Medicare as their primary coverage.

COBRA Member Rights

While participating in COBRA coverage, a qualified individual has the same right to coverage as all active employees. That means a COBRA subscriber has the right to add or drop dependents and/or add optional coverage during the annual Open Enrollment period.

A former employee or dependent who elected to enroll under COBRA has the same opportunity to enroll in any other SHBP/SEHBP coverage offered by the former employer during the Open Enrollment period (as long as the employee or dependent was eligible for that coverage when first enrolling in COBRA). For State employees, eligible coverage would include a SHBP medical plan, dental plan, and the State Prescription Drug Plan. However, all COBRA benefits will end no later than the original COBRA termination date. The addition of a benefit during Open Enrollment does not extend the maximum COBRA coverage period.

All COBRA subscribers receive Open Enrollment information, mailed directly to the address on file with the SHBP/SEHBP, prior to the start of the Open Enrollment period.

COBRA Termination

COBRA coverage through the SHBP/SEHBP will terminate when any of the following situations occur:

- The eligibility period expires;
- The COBRA subscriber fails to pay premiums in a timely manner;
- The COBRA subscriber becomes covered under Medicare (affects health insurance coverage only, does not affect dental or prescription coverage) after COBRA coverage is elected;
- The COBRA subscriber becomes covered under another group plan as either the member or the dependent; or
- The employer (or former employer) no longer provides SHBP/SEHBP coverage to any of its employees. In this case, the employer will provide the employees the opportunity to continue coverage through the new health benefits provider.

COBRA Notification — General

The COBRA law requires employers to:

- Notify the employee and dependents of the COBRA provisions when the employee and dependents are first enrolled;
- Notify the employee, the spouse/partner and children of their right to purchase continued coverage when the employer becomes aware of a COBRA event that causes a loss of coverage;
- Send the *COBRA Notice** and instructions to access Benefitsolver within 14 calendar days of receiving notice that a qualifying event has occurred, and;
- Maintain records documenting the employer's compliance with the COBRA law.

COBRA Notification for New Employees

Employers are required by the federal COBRA law to notify the employee and dependents of the COBRA provisions when the employee and dependents are first enrolled in the SHBP/SEHBP. The *COBRA Notice* is intended to inform employees of their rights and obligations under this federal law.

The letter must be distributed to all new employees and their dependents enrolling in the SHBP/SEHBP within 90 days of enrollment. The letter must be addressed to the employee and dependents and mailed to the address furnished by the employee. The employer must keep a record of the notification.

If an employee already enrolled in the SHBP/SEHBP adds a spouse/partner to his or her coverage, the spouse/partner must be notified about COBRA within 90 days of the date coverage begins.

The COBRA notification must be written and must be received by the employee and covered eligible dependents.

Note: First class mail addressed "To the Family of" the employee sent to the home address meets this requirement. Hand delivery to the employee is not in compliance with the law.

Businessolver has provided each employer with a COBRA package that includes an initial notification letter. The initial COBRA notification letter indicating "IMPORTANT NOTICE" may be reproduced on employer letterhead and mailed to new employees and their dependents.

COBRA Notification after a COBRA Event

The employer is required by federal regulation to notify the employee, spouse/partner, and/or dependents of their rights to purchase continued health coverage

*Employers of locations who offer private prescription or dental coverage will be responsible for issuing the COBRA Notice for those plans.

within 14 days of receiving notice that there has been a COBRA qualifying event that causes a loss of coverage.

It is, however, the employee's responsibility to notify the employer of a COBRA-qualifying event (e.g., divorce, child losing dependent status) within 60 days of the event. If the employee does not inform the employer of the change in status within the 60-day period, the employee may forfeit the dependent's right to COBRA.

Instructions regarding how to access Benefitsolver to enroll in COBRA coverage, and a rate chart should be sent in addition to the *COBRA Notice* issued by Businessolver. The notice will give the date when coverage will end and the period of time over which coverage may be extended. The employer must maintain records documenting compliance with the COBRA law.

The Centers for Medicare and Medicaid Services (CMS) and COBRA

The Centers for Medicare and Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services, oversees COBRA continuation of coverage as it applies to group health plans sponsored by state and local governmental employers (Title XXII of the Public Health Service Act; 42 U.S.C. 300bb-1 through 300bb-8). CMS will assist qualified beneficiaries, state and local governmental employers, and group health plan administrators in understanding their rights and responsibilities with respect to public sector COBRA continuation coverage.

HIPAA REQUIREMENTS

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that includes important protections for millions of working Americans and their families who have preexisting medical conditions, or might suffer discrimination in health coverage based on a factor that relates to an individual's health.

HIPAA requires health plans, such as the SHBP/SEHBP, to maintain the privacy of any personal information relating to its members' physical or mental health (see the Notice of Privacy Practices to Enrollees in the SHBP/SEHBP below).

HIPAA contains several provisions that affect the SHBP/SEHBP and its participating employers. Employers participating in the SHBP/SEHBP are required to comply with the requirements of HIPAA by:

- Notifying all newly enrolling employees and their family members of the SHBP/SEHBP's compliance with federal health insurance regulations. The employer should include the *Notice to SHBP/SEHBP Participants* about compliance with federal health insurance requirements with the COBRA mailing to all new employees;
- Providing a *Notice of Privacy Practices to Enrollees in the SHBP/SEHBP*, describing how medical information about employees enrolled in the SHBP/SEHBP may be used and disclosed and how the employees themselves can get access to this information;
- Providing a *Member Authorization Form for Use and Disclosure of Protected and Private Information*, enabling SHBP/SEHBP enrollees to specify what protected health information the SHBP/SEHBP may use and disclose, and to whom and for what purpose it may be disclosed, as well as the period of time during which the use/disclosure may occur;
- Providing employers with the Required Notices to SHBP/SEHBP Enrollees to be distributed to all newly-enrolled employees and their family members; and
- Establishing procedures to provide departing employees with a *HIPAA: Certificate of Group Health Plan Coverage* form, which verifies group health

plan enrollment and termination dates upon the employee's termination.

For additional HIPAA information, go to: www.cms.gov

OTHER FEDERAL HEALTH INSURANCE REQUIREMENTS

Employers must also inform new enrollees about two additional federal health insurance requirements: The Mental Health Parity Act of 1996, and the Newborns' and Mothers' Health Protection Act of 1996. All SHBP/SEHBP health plans meet or exceed both of these federal requirements.

Mental Health Parity Act

The Mental Health Parity Act of 1996 requires that the dollar limitations on mental health benefits are not lower than those of medical or surgical benefits.

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act of 1996 requires that health plans provide a minimum level of coverage for newborns and mothers, generally 48 hours for a vaginal delivery and 96 hours for a cesarean delivery.