NJDPB
Pensions & Benefits
Explore Your Benefits

Summary Program Description Guidebook

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

HB-0505-0225

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INTRODUCTION

The State Health Benefits Program (SHBP) was established in 1961. It offers medical, dental, and prescription drug 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) was established in 2007. It offers medical, dental, and prescription drug 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/SEHBP.

The purpose of this *Summary Program Description* is to provide an overview of the plans provided through the SHBP/SEHBP. The individual plans' member guidebooks provide detailed information about each plan and should be used to assist you in making informed health care decisions for you and your family. Every effort has been made to ensure the accuracy of the *Summary Program Description;* however, State law and the New Jersey Administrative Code govern the SHBP/SEHBP. If you believe that there are any discrepancies between the information presented in this booklet and/or plan documents and the law, regulations, or contracts, then the law, regulations, and contracts will govern. However, if you are unsure whether a procedure is covered, contact your plan before you receive services to avoid any denial of coverage issues that could result.

Any reference in this *Summary Program Description* to the "Programs" will mean both the SHBP/SEHBP unless otherwise indicated.

If, after reading this guidebook, you have any questions, comments, or suggestions regarding this material, please write to:

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

You may call us at (609) 292-7524, or send email to: ***pensions.nj@treas.nj.gov***

Refer to the "Health Benefits Contact Information" section for additional information on contacting the SHBP/SEHBP and their related health services.

ACTIVE EMPLOYEE ELIGIBILITY

Enrollments, terminations, changes to coverage, etc. must be submitted via Benefitsolver. If you have any questions concerning eligibility, you should contact the NJDPB Office of Client Services at (609) 292-7524.

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

Any employee or officer of a local employer or the State who was enrolled on or before May 21, 2010, is eligible for continued coverage based on the minimum work hour requirements in place prior to May 21, 2010, provided there is no break in the employee's/officer's service or reduction in work hours.

State Employees

To be eligible for State employee coverage, you must work full-time for the State of New Jersey or be an appointed or an elected officer of the State of New Jersey (this includes employees of a State agency or authority and employees of a State college or university). For State employees, full-time requires at least 35 hours per week or more if required by contract or resolution.

The following categories of employees are also eligible for coverage.

- **State Part-Time Employees** — A part-time employee of the State — or a part-time faculty member at an institution of higher education that participates in the SHBP — will be eligible for coverage under an SHBP medical plan and the Prescription Drug Plans if the employee is also enrolled in a State-administered retirement system. The employee must pay the full cost of the coverage. A part-time employee will not qualify for employer- or State-paid post-retirement health benefits, but may enroll in the SHBP Retired Group at his/her own expense provided the employee was covered by the SHBP up to the date of retirement. See the *Health Benefits Coverage for Part-Time Employees* Fact Sheet for details.

- **State Colleges and Universities** — To determine hours worked per week by adjunct faculty members, State college and university employers should credit adjunct faculty with eight hours for every day the employee comes to work. For example, if the employee teaches one course per semester, for 50 minutes, three days a week; the employee would be credited with 24 hours of work per week.
- **State Intermittent Employees** — Certain intermittent State employees who have worked 750 hours in a Fiscal Year (July 1 - June 30) will be eligible for coverage under a SHBP medical plan and the Prescription Drug Plan. Eligible intermittent employees who maintain 750 hours of work per year continue to qualify for health benefits in subsequent years. See the *Health Benefits Coverage for State Intermittent Employees* Fact Sheet for details.
- **New Jersey National Guard** — A member of the New Jersey National Guard who is called to State active duty for 30 days or more is eligible to enroll in coverage under an SHBP medical plan and the Prescription Drug Plan at the State's expense. Upon enrollment, the member may also enroll eligible dependents. The Department of Military and Veteran's Affairs is responsible for notifying eligible members and for notifying the NJDPB of members who are eligible.

Local Employees

To be eligible for local employer coverage, you must be a full-time employee or an appointed or elected officer receiving a salary from a local employer (county, municipality, county or municipal authority, board of education, etc.) that participates in the SHBP/SEHBP. Each participating local employer defines the minimum hours required for full-time by a resolution filed with the NJDPB, but it can be no less than 25 hours per week or more if required by contract or resolution, or 35 hours per week for an elected or appointed official who becomes eligible after May 21, 2010. Employment must also be for 12 months per year except for employees whose usual work schedule is 10 months per year (the standard school year).

- **Local Part-Time Employees** — A part-time faculty member employed by a county college that participates in the SEHBP is eligible for coverage under an SEHBP medical plan — and if provided by the employer, the Prescription Drug Plan — if the faculty member is also enrolled in a State-administered retirement system. The faculty member must pay the full cost of the coverage. A part-time faculty member will not qualify for employer- or State-paid post-retirement health care benefits, but may enroll in the SEHBP Retired Group at his or her own expense provided the faculty member was continuously covered by the SEHBP up to the date of retirement. See the *Health Benefits Coverage for Part-Time Employees* Fact Sheet for details.

Eligible Dependents

Your eligible dependents are your spouse, civil union partner, or same-sex domestic partner and/or your eligible children (as defined below). 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. It is the responsibility of the member to remove the dependent from coverage using Benefitsolver when the relationships defined below come to an end.

Spouse — A person to whom you are legally married. A photocopy of the government issued marriage certificate and additional supporting documentation are required for enrollment.

Civil Union Partner — A person of the same sex with whom you have entered into a civil union prior to October 21, 2013. A photocopy of the *New Jersey Civil Union Certificate*, or a valid certification from another jurisdiction that recognizes same-sex civil unions, and additional supporting documentation are required for enrollment. The cost of civil union partner coverage may be subject to federal tax (see your employer or the *Civil Unions and Domestic Partnerships* Fact Sheet for details).

Domestic Partner — A person of the same sex with whom you have entered into a domestic partnership prior to February 19, 2007, as defined under P.L. 2003, c. 246 (Chapter 246), the Domestic Partnership Act. The domestic partner of any State employee, State retiree, or an eligible employee or retiree of a participating local public entity that adopts a resolution to provide Chapter 246 health benefits, is eligible for coverage. A photocopy of the *New Jersey Certificate of Domestic Partnership* dated prior to February 19, 2007 (or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners), and additional supporting documentation are required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer or the *Civil Unions and Domestic Partnerships* Fact Sheet for details).

Children — In compliance with the federal Patient Protection and Affordable Care Act (PPACA), coverage is extended for children, specifically natural, adopted, and stepchildren, until age 26, regardless of the child's marital, student, or financial dependency status. A photocopy of the child's government issued birth certificate that includes the covered parent's name is required for enrollment. See the Dependent Documentation Requirements Fact Sheet on our website for more information about the documentation a member must provide when enrolling a new dependent for coverage

For a stepchild, provide a photocopy of the child's birth certificate showing the spouse/partner's name as a parent and a photocopy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner.

For foster children and children in a guardian-ward relationship under age 18, provide a photocopy of the child's birth certificate and additional supporting legal documentation that attest to the legal guardianship by the covered employee (see the "Required Documentation for Dependent Eligibility and Enrollment" section).

Coverage for an enrolled natural, adopted, or stepchild ends on December 31 of the year in which he or she turns age 26 (see the "COBRA Coverage" section, or the "Dependent Children With Disabilities" and the "Over Age Children Until Age 31" sections for continuation of coverage provisions).

Dependent Children With Disabilities — If a child is not capable of self-support when he or she reaches age 26 due to a mental or physical disability, he or she may be eligible for a continuance of coverage.

To request continued coverage, you should obtain an *Application for Continued Enrollment for Dependents with Disabilities* available on our website at ***www.nj.gov/treasury/pensions*** or write to:

New Jersey Division of Pensions & Benefits
Health Benefits Bureau
P.O. Box 299
Trenton, NJ 08625-0299

The application and proof of the child's condition must be given to the NJDPB no later than 31 days after the date coverage would normally end. Since coverage for children ends on December 31 of the year they turn 26, you have until January 31 to file the *Application for Continued Enrollment for Dependents with Disabilities.*

Coverage for children with disabilities may continue only while (1) you are covered through the SHBP/SEHBP, (2) the child continues to be disabled, (3) the child is unmarried, (4) the child resides with the custodial parent, and (5) the child remains dependent on you for support and maintenance. The length of the approval is designated in your approval letter. You will be contacted periodically to verify that the child remains eligible for continued coverage. See the *Health Benefits Coverage Continuation for Over Age Children with Disabilities* Fact Sheet for further information.

Over Age Children Until Age 31 — Certain children over age 26 may be eligible for coverage until age 31 under the provisions of P.L. 2005, c. 375 (Chapter 375), as amended by P.L. 2008, c. 38 (Chapter 38). This includes a child by blood or law who is under the age of 31; is 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.

Under Chapter 375, an over age child does not have any choice in the selection of benefits and is enrolled in exactly the same plan or plans (medical and/or prescription drug) that the covered parent has selected. If the parent is enrolled in a MA plan then the child will be enrolled in the corresponding non-Medicare plan. The covered parent or child is responsible for the entire cost of coverage. There is no provision for dental or vision benefits.

Coverage for an enrolled over age child will end when the child no longer meets any one of the eligibility requirements or if the required payment is not received. Coverage will also end if the covered parent's coverage ends. Coverage ends on the first of the month following the event that makes the dependent ineligible, or up until the paid-through date in the case of non-payment.

See the *Health Benefits Coverage of Children Until Age 31 under Chapter 375* Fact Sheet for details.

Medicare Coverage While Employed

In general, it is not necessary for a Medicare-eligible employee, spouse, civil union partner, same-sex domestic partner, or child(ren) to be covered by Medicare while the employee remains actively at work. However, if you or your dependents become eligible for Medicare due to End Stage Renal Disease (ESRD), and the 30-month coordination of benefits period has ended, you and/or your dependents must enroll in Medicare Part A and Part B even though you are actively at work. For more information, see the "Medicare for Retirees" section.

RETIREE ELIGIBILITY

The following individuals will be offered SHBP Retired Group coverage for themselves and their eligible dependents:

- Full-time State employees, employees of State colleges/universities, autonomous State agencies and commissions, or local employees who were covered by, or eligible for, the SHBP at the time of retirement and begin receiving a monthly retirement benefit or lifetime annuity immediately following termination of employment;
- Tier 4 or 5 members of the PERS who were eligible for SHBP coverage as active members and are approved for long-term disability insurance coverage;
- Part-time State employees and part-time faculty at institutions of higher education that participate in the SHBP if enrolled in the SHBP at the time of retirement;
- Participants in the Alternate Benefit Program (ABP) eligible for the SHBP who retire or those who are on a long-term disability and begin receiving a monthly lifetime annuity immediately following termination of employment;
- Certain local policemen or firemen with 25 years or more of service credit in the retirement system

or retiring on a Disability Retirement if the employer does not provide any payment or compensation toward the cost of the retiree's health benefits. A qualified retiree may enroll at the time of retirement or when he or she becomes eligible for Medicare. See the *Health Benefits Retired Coverage Under Chapter 330* Fact Sheet for more information;

- Surviving spouses/partners and/or eligible children who were covered by the retiree's plan at his/her time of death; and
- Surviving spouses/partners and eligible children of Police and Firemen's Retirement System (PFRS) members or State Police Retirement System (SPRS) members killed in the line of duty.

The following individuals will be offered SEHBP Retired Group coverage for themselves and their eligible dependents:

- Full-time members of the Teachers' Pension and Annuity Fund (TPAF) and school board or county college employees enrolled in the Public Employees' Retirement System (PERS) who retire with less than 25 years of service credit from an employer that participates in the SEHBP;
- Tier 4 or 5 members of the TPAF who were eligible for SEHBP coverage as active members and are approved for long-term disability insurance coverage;
- Full-time members of the TPAF and school board or county college employees enrolled in the PERS, who retire with 25 years or more of service credit in one or more State- or locally-administered retirement systems or who retire on a Disability Retirement, even if their employer did not participate in the SEHBP. This includes those who elect to defer retirement with 25 or more years of service credit in one or more State- or locally-administered retirement systems (see the "Aggregate of Pension Membership Service Credit" section);
- Full-time members of the TPAF or PERS who retire from a non-participating board of education, vocational/technical school, or special services commission who maintain participation in the health benefits plan of their former employer may enroll in the SEHBP upon becoming eligible for Medicare;
- Participants in the Alternate Benefit Program (ABP) eligible for the SEHBP who retire or those who are on a long-term disability and begin receiving a monthly lifetime annuity immediately following termination of employment;
- Part-time faculty at institutions of higher education that participate in the SHBP/SEHBP if enrolled in the SHBP/SEHBP at the time of retirement; and
- Surviving spouses/partners and/or eligible children who were covered by the retiree's plan at his/her time of death.

Eligibility for SHBP/SEHBP membership for the individuals listed in this section is contingent upon meeting two conditions:

1. You must be immediately eligible for a retirement allowance from a State- or locally-administered retirement system (except certain employees retiring from a school board or community college, or approved for long-term disability); and
2. You were a full-time employee and eligible for employer-paid medical coverage immediately preceding the effective date of your retirement (if you are an employee retiring from a school board or community college under a Deferred Retirement with 25 or more years of service, you must have been eligible at the time you terminated your employment), or a part-time State employee or part-time faculty member who is enrolled in the SHBP/SEHBP immediately preceding the effective date of your retirement.

This means that if your active coverage lapses because of a leave of absence, reduction in hours, or termination of employment prior to your retirement or you defer your retirement for any length of time after leaving employment, you will lose your eligibility for Retired Group health coverage (this does not include former full-time employees enrolled in TPAF and PERS board of education or county college employees who retire with 25 or more years of service).

Note: If you continue group coverage through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (see the "COBRA Coverage" section) until your retirement becomes effective, you will be eligible for retired coverage under the SHBP/SEHBP.

Otherwise-qualified employees whose coverage is terminated prior to retirement but who are later approved for a Disability Retirement will be eligible for coverage under the Retired Group beginning on the employee's retirement date. If the approval of the Disability Retirement is delayed, members will have the choice to enroll timely or retroactively for a period of no more than one year.

Aggregate of Pension Membership Service Credit

Upon retirement, a full-time State employee, or a board of education or county college employee who has 25 years or more of service credit, is eligible for full or partial State-paid health benefits under the SHBP/SEHBP. An employee of a local government who has 25 years or more of service credit, and whose employer is enrolled in the SHBP and has chosen to provide post-retirement medical coverage to its retirees, is eligible for full or partial employer-paid health benefits under the SHBP.

A retiree under the SHBP/SEHBP may receive this benefit if the 25 years of service credit is from one or more State- or locally-administered retirement systems* and

**Service time from enrollment in the Defined Contribution Retirement Program (DCRP) is not eligible to qualify for health benefits coverage at retirement.*

the time credited is non concurrent.

For PERS or TPAF members, Out-of-State Service, U.S. Government Service, or service with a bi-state or multi-state agency requested for purchase after November 1, 2008, cannot be used to qualify for any State-paid or employer-paid health benefits in retirement.

Eligible Dependents of Retirees

Dependent eligibility rules for Retired Group coverage are the same as for Active Group coverage (see the "Eligible Dependents" section), except for P.L. 2005, c. 334 (Chapter 334) domestic partners described below, and the Medicare requirements and other limitations discussed in the "Retiree Enrollment" section.

Chapter 334 provides that retirees from local entities (municipalities, counties, boards of education, and county colleges) whose employers do not participate in the SHBP/SEHBP, but who become eligible for SHBP/SEHBP coverage at retirement, may also enroll a registered same-sex domestic partner as a covered dependent provided that the former employer's plan includes domestic partner coverage for employees.

Enrolling in Retired Group Coverage

In most cases, the Health Benefits Bureau is notified when you file an application for retirement with the NJDPB. If eligible, you will receive a letter from Benefitsolver inviting you to enroll in Retired Group coverage. Early filing for retirement is recommended to prevent any lapse of coverage or delay of eligibility.

Most eligible members enrolled in coverage as active employees will automatically be enrolled as retirees. Exceptions include those members who: waived coverage as an active employee; have applied for a Disability Retirement or long-term disability insurance; or retired from non-participating employer locations. These members must enroll online through Benefitsolver, accessible via your myNewJersey account or at mynjbenefitshub.nj.gov

If electing to waive SHBP/SEHBP coverage for other group coverage, submit the waiver via Benefitsolver at the time of retirement to ensure eligibility for enrollment in SHBP/SEHBP if and when you lose the other coverage. If you do not enroll on Benefitsolver within 60 days of losing the other coverage, you will not be permitted to enroll at a later date.

If you do not enroll in the Retired Group at the time of retirement, you will not generally be permitted to enroll for coverage at a later date, unless you are subsequently approved for a Disability Retirement. See the *Health Benefits Coverage – Enrolling as a Retiree* Fact Sheet for more information regarding eligibility, enrollment, and other important topics.

If you believe you are eligible for Retired Group coverage and do not receive an offering letter by the date of your retirement, contact the NJDPB Office of Client Services at (609) 292-7524 or send an email to: ***pensions.nj@treas.nj.gov***

Additional restrictions and/or requirements may apply when enrolling in the Retired Group. Be sure to read the "Retiree Enrollment" section.

CHOOSING A MEDICAL PLAN

The SHBP/SEHBP offer employees and retirees of the State of New Jersey and of many county, municipal, and local board of education public employers and their eligible dependents access to a choice of medical plans, prescription drug coverage, and dental plans.

Choosing a medical plan is an important decision and one that requires careful consideration. The following section describes the medical plans. Descriptions of prescription drug coverage and dental plans follow the medical plan description pages.

SHBP Active Group

The following medical plans are offered to most State and participating local government employees:

- **Tiered-Network Plans:** Horizon OMNIA and Aetna Liberty Plus.
- **Preferred Provider Organization (PPO) Plans:** NJ DIRECT/NJ DIRECT 2019 and Freedom/Freedom 2019,* CWA Unity DIRECT/CWA Unity DIRECT 2019 and CWA Unity Freedom/CWA Unity Freedom 2019,** NJ DIRECT 10 and Freedom 10, NJ DIRECT 15 and Freedom 15, NJ DIRECT 1525 and Freedom 1525, NJ DIRECT 2030 and Freedom 2030, and NJ DIRECT 2035 and Freedom 2035.

  Note: NJ DIRECT 10 and Freedom 10 are not available to State Employees.
- **Health Maintenance Organization (HMO) Plans:** Horizon HMO and Aetna HMO. **Note:** The Horizon HMO service area is limited to New Jersey and bordering counties of Delaware, Pennsylvania, and New York.
- **High Deductible Health Plans (HDHP):** NJ DIRECT HDLow and Freedom HDLow, and NJ DIRECT HDHigh and Freedom HDHigh.

SHBP Retired Group

The following medical plans are offered to most State and participating local government retirees.

** Members hired before July 1, 2019, will be enrolled in NJ DIRECT or Freedom. Members hired after July 1, 2019, will be enrolled in NJ DIRECT 2019 or Freedom 2019.*

***Members hired before July 1, 2019, will be enrolled in CWA Unity DIRECT or CWA Unity Freedom. Members hired after July 1, 2019, will be enrolled in CWA Unity DIRECT 2019 or CWA Freedom 2019. These plans are available only to State employees and retirees covered by the Communications Workers of America.*

Non-Medicare:

- **Preferred Provider Organization (PPO) Plans:** NJ DIRECT/NJ DIRECT 2019 and Freedom/ Freedom 2019,* CWA Unity DIRECT/CWA Unity DIRECT 2019 and CWA Unity Freedom/CWA Unity Freedom 2019,** NJ DIRECT 10 and Freedom 10, NJ DIRECT 15 and Freedom 15, NJ DIRECT 1525 and Freedom 1525, NJ DIRECT 2030 and Freedom 2030.
- **Health Maintenance Organization (HMO) Plans:** Horizon HMO and Aetna HMO, Horizon HMO 1525 and Aetna HMO 1525, and Horizon HMO 2030 and Aetna HMO 2030.
- **High Deductible Health Plans (HDHP):** NJ DIRECT HDLow and Freedom HDLow, and NJ DIRECT HDHigh and Freedom HDHigh.
- **Tiered Network Plans:** Horizon OMNIA and Aetna Liberty Plus.

Medicare:

- **Preferred Provider Organization (PPO)(Medicare Advantage) Plans:** Aetna ESA 10 (Freedom 10) and Aetna ESA 15 (Freedom 15).
- **Preferred Provider Organization (PPO)(Supplemental) Plans:** NJ DIRECT 1525 and NJ DIRECT 2030.
- **Health Maintenance Organization (HMO) (Medicare Advantage) Plans:** Aetna HMO and Aetna HMO 1525.
- **Health Maintenance Organization (HMO)(Supplemental) Plans:** Horizon HMO, Horizon HMO 1525, and Horizon HMO 2030.

SEHBP Active Group

The following medical plans are offered to most participating local education employees:

- **Preferred Provider Organization (PPO) Plans:** NJ Educators Health Plan (NJEHP) (Horizon or Aetna), Aetna Garden State Health Plan (GSHP),*** NJ DIRECT 10 and Freedom 10, and NJ DIRECT 15 and Freedom 15.

SEHBP Retired Group

The following medical plans are offered to most local education retirees.

Non-Medicare:

- **Preferred Provider Organization (PPO):** New Jersey Educators Health Plan (NJEHP) (Horizon or Aetna) and Aetna Garden State Health Plan (GSHP).***

Medicare:

- **Preferred Provider Organization (PPO)(Medicare Advantage):** Aetna Educators Medicare Advantage 10, and Aetna Educators Medicare Advantage 15.
- **Preferred Provider Organization (PPO)(Supplemental):** NJ DIRECT 1525 and NJ DIRECT 2030.
- **Health Maintenance Organization (HMO)(Medicare Advantage):** Aetna HMO, and Aetna HMO 1525.
- **Health Maintenance Organization (HMO)(Supplemental):** Horizon HMO, Horizon HMO 1525, and Horizon HMO 2030.

PLAN COVERAGE

While many services are the same from plan to plan, others may vary from one plan to another. It is important that you review the services provided by your plan, or one you are considering joining, to determine if the services meet the needs of yourself and your dependents.

CHOICE OF PROVIDER

The Horizon OMNIA and Aetna Liberty Plus plans give members the flexibility to visit high-quality practitioners in the carrier's managed care network and no referrals are required. There is lower member cost sharing when utilizing Tier 1 providers. Tier 1 refers to specific doctors, hospitals, and other health care professionals who offer high-quality, cost-effective care. Tiered-Network plan members also have the flexibility to see any Tier 2 provider included in the managed care network, but with slightly higher cost sharing. There is no out-of-network coverage with the Tiered Plans.

Under the NJ DIRECT and Freedom plans, and the New Jersey Educators Health Plan (NJEHP) (Horizon or Aetna), members may see any physician nationwide and do not need to select a Primary Care Physician (PCP) for in-network care. NJ DIRECT and Freedom plans have in-network benefits which apply when you select and use participating providers. NJ DIRECT and Freedom also offer out-of-network benefits that allow you to use any licensed medical provider or hospital facility. In-network benefits are payable subject to applicable copayments. Out-of-network benefits are payable subject to a deductible and coinsurance. Members are also responsible for any amount payable over the "reasonable and customary" allowance.

* *Members hired before July 1, 2019, will be enrolled in NJ DIRECT or Freedom. Members hired after July 1, 2019, will be enrolled in NJ DIRECT 2019 or Freedom 2019.*

** *Members hired before July 1, 2019, will be enrolled in CWA Unity DIRECT or CWA Unity Freedom. Members hired after July 1, 2019, will be enrolled in CWA Unity DIRECT 2019 or CWA Freedom 2019. These plans are available only to State employees and retirees covered by the Communications Workers of America.*

*** *Members hired on or after July 1, 2020, must be enrolled in the New Jersey Educators Health Plan (NJEHP) (Horizon or Aetna) or Aetna Garden State Health Plan (GSHP).*

Under the Garden State Health Plan, members must use a designated provider within the Aetna Whole Health℠ Network to be covered at the in-network level. Members are provided access to a special network of primary care doctors, specialists, hospitals, and urgent care facilities – all located exclusively in New Jersey. Care received outside of the New Jersey network of providers will be covered for emergency services only. Any non-emergency care will not be covered, and full out-of-pocket payment will be expected.

Retired Group members enrolled in Medicare Advantage (MA) plans can visit any provider who accepts Medicare. The MA PPO plans provide an Extended Service Area (ESA). SHBP retirees can enroll in either Aetna MA PPO ESA 10 or Aetna MA PPO ESA 15. SEHBP Retired Group members can enroll in either Aetna Educators Medicare Advantage 10 or Aetna Educators Medicare Advantage 15.

The Horizon HMO and Aetna HMO plans have participating providers from which you must select a PCP. That physician coordinates all of your care. Referrals must be obtained from your PCP in order for you to visit a specialist. An annual gynecologist visit does not require a referral. Further information can be found in each plan's summary or you may call the plan directly.

The Horizon HDHP and Aetna HDHP plans provide both in-network and out-of-network services. Members may see any physician, licensed medical provider, or hospital facility nationwide, and do not need to select a PCP for in-network care. One annual deductible is combined for in-network and out-of-network medical and prescription drug products and services. The entire deductible must be met before any eligible charges are reimbursed. The annual deductible applies to all services unless otherwise indicated. No copayments apply

How to Access Information That Can Help You Choose a Provider

To help you find a physician, or to determine that a physician you wish to use is in a certain plan, call the plan directly or check the plan's website for a listing of the participating physicians. Plan telephone numbers are found in the "Health Benefits Contact Information" section.

SHBP/SEHBP members may access provider directories available through Horizon and Aetna to search for quality in-network healthcare providers in their area. These comprehensive search tools can be found on the Horizon and Aetna websites.

Member Guidebooks

For additional information about deductibles, coinsurance, and other out-of-pocket costs, see the medical plan member guidebooks for each of the SHBP/SEHBP plans.

The member guidebooks are plan documents that describe the terms and conditions of coverage and the benefits available under those plans. The guidebooks are available on our website.

PLAN PREMIUMS, COPAYMENTS, AND OTHER COSTS

Minimum Contribution for Health Coverage

For State employees paid via the State Centralized Payroll Unit and most employees of State colleges and universities, the contribution is determined as a specified percentage of the health benefits/prescription drug premiums for a salary range, but not less than 1.5 percent of salary or a percentage of salary for certain negotiated labor groups, dependent upon plan selection.

The calculation of the minimum 1.5 percent of salary is based on the employee's base contractual salary. In most instances, that means the salary on which pension contributions are based. However, for employees hired after July 2007 for whom pensionable salary is limited to the salary on which Social Security contributions are based, the employee's total base salary would be used. If an employee's salary increases or decreases during the year, the amount of contribution will be adjusted accordingly.

Local government employees are subject to the same contribution changes required by Chapter 78, which were effective immediately for employees whose contracts were expired and employees not covered by a union contract as of June 28, 2011, and commencing upon contract expiration for employees covered by a collective negotiations agreement (CNA).

For local education employees, the contribution is determined as a specified percentage of the health benefits/prescription drug premiums for a salary range, or a percentage of salary dependent on plan selection.

To calculate your total percentage of premiums, combine both the medical plan premium percentage and, if applicable, the prescription drug plan premium percentage for the appropriate level of coverage. Online Contribution Calculators are also available on our website.

Retiree Contributions

There were no changes to contributions for those who retired prior to the enactment of Chapter 78. For active employees who subsequently retire, the following provisions apply for health benefits contributions toward post-retirement medical coverage.

Active State employees (State Departments, State colleges and universities, etc.) with 20 or more years of service credit as of June 28, 2011, are grandfathered at the 1.5 percent of salary/retirement allowance contribution requirement, but must still attain 25 years of service credit prior to retirement to qualify for State- or employer-paid contributions toward post-retirement medical coverage.

Active local government/education employees who attained 20 or more years of service credit as of June 28, 2011, are not subject to the Chapter 78 contribution requirements and will contribute in retirement in accordance with the law applicable to them prior to Chapter 78 or any applicable local ordinance or resolution. Local employees who are eligible to retire with employer-paid medical benefits at age 62 with 15 years of service with the employer, and who met those age and service requirements on or before June 28, 2011, or on or before expiration of a CNA that was in force on June 28, 2011, will contribute in retirement in accordance with the terms of the CNA applicable to them on the date they first met the age and service requirements. Retirees must still attain 25 years of service credit, or age 62 with 15 years of service with the employer, as applicable, prior to retirement to qualify for State- or employer-paid contributions toward post-retirement medical coverage.

Employees who did not have 20 years of service by June 28, 2011, and who attain 25 years of service and retire, will be subject to a contribution toward post-retirement medical coverage based on the applicable percentage of premium as outlined in the previous charts and determined by the annual retirement allowance or a percentage of salary for certain negotiated labor groups, dependent upon plan selection. A minimum contribution of 1.5 percent of the monthly retirement allowance is required. The ABP contribution amount is based on 50 percent of the highest salary earned in the five years prior to retirement.

Note: The retiree's cost is based on the full monthly pension amount before any deductions, including equitable distribution due to a Qualified Domestic Relations Order (QDRO).

Health Benefits Contribution — Percentage of Premium Chart

Note: You must use the active or retired members rate charts to first determine the full cost premium for the plan and coverage level you select. Then, use this chart to determine the percentage of the full cost for which you will be responsible.*

Annual Retirement Allowance Range	Single	Member/ Spouse/Partner or Parent/Child	Family
Less than $20,000	4.5%		
Less than $25,000		3.5%	3%
$20,000 - $24,999.99	5.5%		
$25,000 - $29,999.99	7.5%	4.5%	4%
$30,000 - $34,999.99	10%	6%	5%
$35,000 - $39,999.99	11%	7%	6%
$40,000 - $44,999.99	12%	8%	7%
$45,000 - $49,999.99	14%	10%	9%
$50,000 - $54,999.99	20%	15%	12%
$55,000 - $59,999.99	23%	17%	14%
$60,000 - $64,999.99	27%	21%	17%
$65,000 - $69,999.99	29%	23%	19%
$70,000 - $74,999.99	32%	26%	22%

Annual Retirement Allowance Range	Single	Member/ Spouse/Partner or Parent/Child	Family
$75,000 - $79,999.99	33%	27%	23%
$80,000 - $84,999.99		28%	24%
$80,000 - $94,999.99	34%		
$85,000 - $89,999.99			26%
$85,000 - $99,999.99		30%	
$90,000 - $94,999.99			28%
$95,000 and over	35%		
$95,000 - $99,999.99			29%
$100,000 and over		35%	
$100,000 - $109,999.99			32%
$110,000 and over			35%

**Member contribution is a minimum of 1.5% of base salary towards Health Benefits.*

PRESCRIPTION DRUG BENEFITS

The SHBC and SEHBC require that all covered employees and retirees have access to prescription drug coverage.

The Commissions reserve the right to establish dispensing limits on any medication based on Food and Drug Administration (FDA) recommendations and medical appropriateness. Prior Authorization, Drug Utilization Review, Dose Optimization, Step Therapy, Preferred Drug Step Therapy (PDST), and the Specialty Pharmacy Program are employed to ensure that the medications that are reimbursed under the plan are the most clinically appropriate and cost effective. Volume restrictions also apply to certain drugs such as sexual dysfunction drugs (Viagra, etc.). Certain drugs that require administration in a physician's office may be covered through your medical plan. See the *Prescription Drug Plans Member Guidebook* for more information.

DENTAL PLANS

Dental coverage is available through the Employee Dental Plans and the Retiree Dental Plans.

Employee Dental Plans

The Employee Dental Plans are offered to active State employees and their eligible dependents as a separate dental benefit. Local employers may also elect to provide the Employee Dental Plans to their employees as a separate dental benefit.

The DPB offers two types of dental plans; the Dental Plan Organization (DPO) is an in-network plan only, and the Dental Expense Plans (DEPs) have in- and out-of-network coverage.

- The DPO, sometimes called a Dental Maintenance Organization (DMO) or a Dental Health Maintenance Organization (DHMO), is a company that contracts with a network of providers for dental services. To receive services, you must select a DPO-participating provider. When using the DPO, you pay a copayment for the services provided. Most preventive services have no copayment; restorative and other services have copayments that vary with the type of service. Be sure to confirm that a dentist or dental facility is taking new patients and participates with the DPO before you enroll.
- The Dental Expense Plans are PPO plans that allow you to obtain services from any licensed dentist. After you satisfy an annual deductible (the deductible only applies to non-preventive services), you are reimbursed a percentage of the reasonable and customary charges for covered services. The plans are administered under a contract with the Aetna Life Insurance Company and Horizon. By using Aetna's or Horizon's network of dental PPO providers, you have the opportunity to save on your costs when compared to using out-of-network providers.

For more information about the Employee Dental Plans, see the *Dental Plans – Active Employees* Fact Sheet. Information about reimbursement levels and copayment amounts is in the *Employee Dental Plans Member Guidebook,* available on the NJDPB website.

Retiree Dental Plans

The Retiree Dental Plans are offered to retirees eligible to enroll in a SHBP/SEHBP Retired Group Medical plan. The offered enrollment is one of two basic types of dental plans:

- The Retiree DPO is a company that contracts with a network of providers for dental services. To receive services, you must select a DPO-participating provider. When using the DPO you pay a copayment for the services provided. Most preventive services have no copayment; restorative and other services have copayments that vary with the type of service. Be sure to confirm that a dentist or dental facility is taking new patients and participates with the DPO before you enroll.
- The Retiree Dental Expense Plans, administered by Aetna and Horizon Dental, are PPO plans with in-network and out-of-network benefits that reimburse you for a portion of the expenses you and your enrolled eligible dependents incur for dental care provided by dentists or physicians licensed to perform dental services in the state in which they are practicing. Not all dental services are eligible for reimbursement, and some services are eligible only up to a limited amount. In addition, by using Aetna's or Horizon's network of dental PPO providers, you have the opportunity to save on your costs when compared to using out-of-network providers.

All State and most other retirees who enroll in the Retiree Dental Plans are responsible for paying the full premium cost for coverage.

For more information about the Retiree Dental Plans, see the *Retiree Dental Plans Member Guidebook*, or the *Dental Plans - Retirees* Fact Sheet on the NJDPB website.

EMPLOYEE ASSISTANCE PROGRAMS

Employee Assistance Programs (EAP) are staffed by professional counselors who can help employees and their eligible dependents handle problems such as stress, alcoholism, drug abuse, mental health conditions, and family difficulties. An EAP will provide education, information, counseling, and individual referrals to assist with a wide range of personal or social problems. The EAP will also assist you in obtaining a referral to the proper health care provider, and help in day-to-day communications with your health plan.

An employee's contact with this service is private, privileged, and strictly confidential. No information will be shared with anyone at any time without your written consent.

The following EAP services are available to State Employees:

State Employee Advisory Service
(EAS) 24 hours a day. 1-866-EAS-9133

New Jersey
State Police EAP 1-800-FOR-NJSP

Rutgers University
Behavioral Health Care 1-800-327-3678

Employees of local employers may have an EAP available to them. To find out about such services, you should check with your employer's human resources office.

TAX$AVE FOR STATE EMPLOYEES

Tax$ave is a benefit program, defined by Section 125 of the federal Internal Revenue Code (IRC), that allows eligible New Jersey State employees to use pre-tax dollars to pay for qualified medical, dental, and dependent care expenses and thereby increase their take-home pay. The pre-tax deduction effectively reduces the salary on which taxes are computed by the amount of the health, dental, or dependent care deduction. Tax$ave consists of three components:

- The Premium Option Plan (POP) allows eligible New Jersey State employees to make payments for basic health and dental plan premiums on a pre-tax basis, thereby increasing their take-home pay. Any increase in take-home pay will depend on the health and/or dental plan selected and the level of coverage (Single, Member and Spouse/Partner, Parent and Child(ren), or Family).
- The Unreimbursed Medical Spending Account Plan (UMSA), a Flexible Spending Account (FSA) administered by Horizon through Further, allows eligible New Jersey State employees to set aside money to pay for qualified medical and dental expenses not paid by any group benefits plan under which they or their dependents are covered (see the "Civil Unions, Domestic Partners, and Tax$ave" section for limitations).

  Note: Federal law prohibits participation in both a flexible spending account (FSA) such as the UMSA and a health savings account (HSA). Therefore, if you are enrolled in a HDHP, you are not eligible to enroll in this plan.
- The Dependent Care Spending Account Plan (DCSA) allows an eligible New Jersey State employee to set aside funds to pay for anticipated expenses related to dependent care required to permit the employee and spouse to work.

The UMSA and DCSA are administered for the NJDPB by Horizon.

Tax$ave Open Enrollment

State Employees may join Tax$ave or make changes to a Tax$ave account during the Tax$ave Open Enrollment period. Enrollment in the POP is automatic unless enrollment is specifically declined each year.

The *Tax$ave* Fact Sheet outlines the Tax$ave Program and may be obtained from your benefits administrator or from the NJDPB website.

Note: The Tax$ave program is not available to local employees; however, your employer must offer a similar program. Contact your employer to find out about pre-tax IRC Section 125 programs offered by your employer.

EFFECT OF POP PARTICIPATION ON SHBP RULES AND PROCEDURES

Your participation in the POP may affect your participation in the SHBP.

As a State employee, you are automatically enrolled in the POP and save on taxes for any health and/or dental premiums you pay through payroll deductions — unless you decline enrollment at the time you first become eligible for health and dental plan coverage or during the Tax$ave Open Enrollment period (see the "Declining POP" section).

The Tax$ave Program is strictly regulated by the Internal Revenue Service (IRS) because of the tax advantages provided under the POP. IRS rules require that for an employee covered by the POP, payroll deductions for health and/or dental plan benefits remain the same for the entire plan year. Therefore, no coverage level changes can be made to your health and/or dental plan enrollment that would result in a change in the amount of your deduction unless a qualifying event has occurred. If a qualifying event does occur (see the "Qualifying Events" section), you may make a change by submitting a completed application to your employer within 60 days of a qualifying event or during the annual Tax$ave Open Enrollment period.

Qualifying Events

- A marriage (employee may enroll spouse and any other eligible dependents).
- Addition of an eligible dependent due to birth, adoption, or legal guardianship.
- A change in family status involving the loss of eligibility of a family member (separation, divorce, death, child turns age 26).
- The termination of a member's employment for any reason, including retirement.
- Taking an approved unpaid leave of absence.
- A change in an eligible dependent's employment status resulting in his/her loss of health and/or dental coverage.
- Such other events that may be determined to be appropriate and in accordance with applicable IRS regulations.

Declining POP

Since enrollment is automatic for employees with health or dental plan deductions, a newly hired employee who does not want to participate in the POP may decline participation by completing a *Declination of Premium Option Plan* form that can be obtained from the employee's Human Resources Representative or Payroll Clerk, or available on our website.

Leave Without Pay (LWOP)

The election in effect at the beginning of the plan year will continue until a change is made during the Tax$ave Open Enrollment period or upon the occurrence of a qualifying event. An employee who declined enrollment in the POP and is on leave during the annual Open Enrollment period may elect enrollment in the POP upon return to active employment.

Civil Unions, Domestic Partners, and Tax$ave

The IRS does not recognize a New Jersey civil union partner or same-sex domestic partner as a dependent for tax purposes in the same manner that it recognizes a spouse or dependent children of an employee. Therefore, your employer may have to treat the civil union partner or same-sex domestic partner SHBP benefit as federally taxable.

As a result, a civil union partner or same-sex domestic partner must be able to qualify as a tax dependent of the employee for federal tax filing purposes — under IRC Section 152 — before an out-of-pocket medical expense incurred by the partner can be reimbursed under the UMSA and before any premiums that the employee pays for the partner's coverage can be made on a pre-tax basis under the POP. See IRS *Publication #503, Dependents*, for additional information on the requirements for establishing dependent status for federal tax purposes.

If the civil union partner or same-sex domestic partner is not a qualified tax dependent of the employee, the partner's SHBP coverage is considered federally taxable and the employee cannot be reimbursed under the UMSA for any out-of-pocket medical expense incurred by the partner, nor make pre-tax payments for the cost of the civil union or domestic partner's coverage under the POP. Pre-tax dollars may still be used to pay for the employee's portion of the cost of his or her own and dependent children's coverage.

The civil union or same-sex domestic partner SHBP benefit is not subject to New Jersey State income tax. If you live outside of New Jersey, you should check with your State's tax agency to determine if the civil union or same-sex domestic partner SHBP benefit is subject to State taxes.

ENROLLING IN HEALTH BENEFITS

Multiple Coverage under the SHBP/SEHBP is Prohibited

State statute specifically prohibits two members who are each enrolled in 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, making the spouse and children the dependents and ineligible for any other SHBP/SEHBP coverage; or one may choose Single coverage and the spouse may choose Parent and Child(ren) coverage.

Supporting Documentation Required for Enrollment of Dependents

The SHBP/SEHBP are required to ensure that only eligible employees, retirees, and their dependents, are receiving health care coverage under the program. Employees or retirees who enroll dependents for coverage (spouses, civil union partners, domestic partners, children, disabled dependents, and over age children continuing coverage) must submit supporting documentation when completing the online enrollment application to add a dependent. See the *Dependent Documentation Requirements* Fact Sheet on our website for more information about the documentation a member must provide when enrolling a new dependent for coverage.

ACTIVE EMPLOYEE ENROLLMENT

You are not covered until you enroll in the SHBP/SEHBP. All active employees must complete their enrollment via Benefitsolver and provide all required supporting documentation. Benefitsolver can be accessed via your myNewJersey account or at mynjbenefitshub.nj.gov.

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 to do so (see "Change of Coverage" section for exceptions).

Open Enrollment

An annual Open Enrollment period is held for all eligible State employees and local participating employees. Specific dates for the Open Enrollment period are announced in advance. Coverage changes made during the Open Enrollment period will be effective the designated payroll period of the new plan year for State employees paid through the State's Centralized Payroll Unit, and January 1 of the following year for all other State and local employees. Enrollments/changes must be submitted online through Benefitsolver by the deadline indicated in the Open Enrollment announcement materials.

The annual Open Enrollment period is your opportunity to make changes to the coverage provided to you and your dependents. During the Open Enrollment period, you may:

- Enroll in any of the plans offered for which you are eligible, if you have not previously enrolled;
- Change to another eligible health plan;
- Enroll in, or change dental plans (if eligible and enrolled in your previous dental plan for a minimum of 12 months);
- Add eligible dependents you have not previously enrolled (including over age children eligible under Chapter 375, see the "Eligible Dependents" section); and
- Delete dependents (this can also be done at any time during the year).

Waiver of Coverage

An employer other than the State participating in the SHBP/SEHBP may allow an employee who is covered as a dependent under a spouse's or partner's non-SHBP/SEHBP employer-provided health benefits coverage to waive SHBP/SEHBP health benefits coverage and be reimbursed up to 25 percent of the amount saved by the employer, or $5,000, whichever is less. Coverage may be resumed if the spouse's or partner's dependent coverage is no longer in effect. The decision of an employer to allow its employees to waive coverage and the amount of consideration to be paid are not subject to collective bargaining.

Change of Coverage

To change your coverage due to any of the circumstances listed below, you must submit an enrollment and all required supporting documentation online through Benefitsolver within 60 days of the event. See the "Required Documentation for Dependent Eligibility and Enrollment" section for more information about the documentation a member must provide when enrolling a new dependent for coverage.

You are eligible to change your level of coverage within the same plan under the following circumstances:

- You marry and want to enroll your spouse and newly eligible children. A photocopy of the *Marriage Certificate,* and/or birth certificates for any children, and all required supporting documentation must accompany the online application;
- You need to enroll an eligible civil union or same-sex domestic partner and/or newly eligible children. A photocopy of the *New Jersey Civil Union Certificate, Certificate of Domestic Partnership*, and/or birth certificates for any children, and all required supporting documentation must be uploaded into Benefitsolver (may not apply to all employees, see the "Eligible Dependents" section for additional information about eligible same-sex domestic partners);
- You need to enroll a child. A photocopy of legal documentation (birth certificate, adoption or guardianship papers, etc.) must be uploaded into Benefitsolver;
- You have a change in family status involving the loss of eligibility of a family member (divorce; dissolution of a civil union or same-sex domestic partnership; death);
- Your dependent's employment status changes resulting in a loss of health coverage. A photocopy of your dependent's *Certificate of Continued Coverage* and required supporting documentation must be uploaded into Benefitsolver; or
- You are going on a leave of absence and cannot afford to pay for coverage. See the "Leaves of Absence" section.
- You have a newborn baby.

You are eligible to change your coverage to another plan under the following circumstance:

- You return from a leave of absence. See the "Return From Leave of Absence" section.

For additional information on the eligibility of dependents, please refer to the *Dependent Documentation Requirements* fact sheet, available on our website.

Effective Dates of Coverage

There is a waiting period of two months following your date of hire before your health benefits coverage begins, provided you submit a health benefits enrollment

via Benefitsolver and all required supporting documentation. Your enrolled dependent's coverage is effective the same date as yours, provided you have paid any required contribution.

Coverage for State biweekly employees begins on the first day of your fifth payroll period. The exact date of your coverage will be determined by the State's Centralized Payroll date schedule. Contact your benefits administrator or human resources representative if you need to know the exact date of coverage.

For all other employees, your coverage begins on the first day following two months of employment. For example, if you start work on September 15, your coverage will be effective November 15. The following exceptions apply to this effective date of coverage:

- If you have at least two months of service on the date your employer joins the SHBP/SEHBP, your coverage starts on the date your employer enters the program;
- If you have an annual contract, are paid on a 10-month basis, and begin work at the beginning of the contract year, your coverage will begin on September 1; and
- If you were enrolled in the SHBP or SEHBP 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 (see the "Transfer of Employment" section).

For State monthly, local government, and education employees, coverage changes involving the addition of dependents are effective retroactive to the date of the event (marriage, civil union, birth, adoption, etc.) provided enrollment is completed in Benefitsolver and all required supporting documentation is filed within 60 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 (marriage, civil union, birth, adoption, etc.) provided that the enrollment and all required supporting documentation is uploaded within 60 days of the event via Benefitsolver.

Deletion of dependents is effective on a timely or prospective basis, depending upon receipt of the enrollment change by the Health Benefits Bureau, except for the following:

- Dependent children are automatically terminated at the end of the year they attain age 26 and we do not require any member action to remove the child; or
- Children covered under the provisions of Chapter 375 are terminated from coverage on the first of the month following the event that no longer makes them eligible.

Transfer of Employment

If you transfer from one participating employer to another, including transfer within State employment, coverage may be continued without any waiting period provided that:

- You are still enrolled by the SHBP or SEHBP (COBRA, State part-time, and part-time faculty coverage excluded) when you begin in your new position; or
- You transfer from one participating employer to another; and
- The new employer contacts the Health Benefits Bureau.

Leaves of Absence

Leaves of absence encompass all approved leaves with or without pay. These include:

- Approved leave of absence for illness;
- Approved leave of absence other than illness;
- Family Leave Act (federal and State);
- Furlough;
- Workers' Compensation; and
- Suspension (COBRA continuation only).

While you are on a leave of absence, you can choose to reduce your level of coverage for the duration of your leave and increase it again when you return from leave. For example, you can reduce Family coverage to either Parent and Child(ren) or Single coverage. Please note that it is necessary to use Benefitsolver to decrease your coverage and also to reinstate it through Benefitsolver once you return to work. Contact your benefits administrator or human resources representative for more information concerning coverage while on leave of absence.

Family and Medical Leave Act

Enrolled State and local employees are entitled to have their health benefits coverage continued for up to 12 weeks at the expense of their employer while they are on family leave. You must remit to your employer, in advance, that portion of the premiums you normally pay.

Furlough

If you take an approved furlough, your health benefits coverage will continue for up to 30 days of furlough. However, you must remit to your employer, in advance, any contribution or portion of the premiums that you normally pay. Extensions beyond the normal 30 furlough days are an exception and you will have to pay, in advance, for the full cost of health benefits coverage for your extended furlough, or drop your coverage for the entire benefit period in which you take an extended furlough day.

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 contribution level as when you were an active employee. You must remit to your employer, in advance, the portion of the premiums that you would normally pay.

Suspension

If you are suspended from work, you are not eligible for employer-paid coverage. You may be eligible for coverage under COBRA (see the "COBRA Coverage" section) under certain circumstances. Contact your benefits administrator or human resources representative for more information concerning coverage while on suspension.

Return From Leave of Absence

If your coverage has terminated while on an approved leave of absence, when you return from the leave, your benefits and those of your eligible family members are reinstated after you use Benefitsolver online and include any required documentation for new dependents. You must complete this enrollment within 60 days after you return to work. Coverage becomes effective on the date you return to work if you are a State monthly or local employee, or on the first day of the pay period in which you return to work if you are a State biweekly employee. You may enroll in any plan at any level of coverage for which you are eligible when you return from an approved leave of absence. This reinstatement provision applies to all approved leaves.

If you retained your coverage at a reduced level while on an approved leave of absence, you may return to your former level of coverage or any other eligible level of coverage, upon your return to work you must make your enrollment change through Benefitsolver online.

If you retained your coverage at a reduced level while on a leave of absence and were not actively at work during an Open Enrollment period, you may make Open Enrollment-types of changes to your coverage when you return to work. These changes will be effective immediately upon your return to work.

If you are absent for a full pay period (State biweekly employee) and your coverage was terminated, or you purchased COBRA coverage while on leave, you must use Benefitsolver online within 60 days of the first day of your return to work. In addition, filing your application as soon as possible upon your return to work will help to ensure a timely re-enrollment.

End of Coverage

Coverage for you and your dependents will end if:

- You voluntarily terminate coverage;
- Your employment terminates;
- Your hours are reduced so you no longer qualify for coverage;
- You do not make required premium payments;
- Your plan discontinues services in your area and you do not submit an enrollment through Benefitsolver to change to another plan;
- Your employer ceases to participate in the SHBP or SEHBP; or
- The SHBP or SEHBP are discontinued.

Coverage for your dependents (including over age children eligible under Chapter 375, see the "Eligible Dependents" section) will end if:

- Your coverage ceases for any of the reasons listed above;
- You die (dependent coverage terminates the first day of the biweekly coverage period following the date of death of State employees paid through the State's Centralized Payroll Unit, or the first of the month following the date of death for all other employees);
- Your dependent is no longer eligible for coverage (divorce of a spouse; dissolution of a civil union or same-sex domestic partnership; child is over age 26 — age 31 if covered under Chapter 375 — except where the over age child qualifies for coverage due to disability); or
- Your dependent becomes enrolled on his/her own as an SHBP or SEHBP subscriber.

Medicare Part A and Part B for Active Employees

In general, it is not necessary for a Medicare-eligible employee, spouse/partner, or dependent child(ren) to be covered by Medicare while the employee remains actively working. However, if you or your dependents become eligible for Medicare due to End Stage Renal Disease (ESRD), and the 30-month coordination of benefits period has ended, you and/or your dependents must enroll in Medicare Parts A and B even though you are actively working. For more information see the "Medicare for Retirees" section.

Medicare Part D

Most employees and/or Medicare-eligible dependents who do enroll in Medicare need not enroll in Medicare Part D Prescription drug coverage; however, some members who qualify for low-income subsidy programs may find it beneficial to enroll in Medicare Part D.

RETIREE ENROLLMENT

You are not covered as a retiree until you enroll in the SHBP/SEHBP. Many members enrolled as active members are automatically enrolled as retirees. If not, you must complete an online enrollment through Benefitsolver and provide all the information requested within 60 days of being offered enrollment. Benefitsolver is accessible via your myNewJersey account or at mynjbenefitshub.nj.gov

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

Waiver of Coverage

As an eligible retiree:

- You may waive coverage with the Retired Group and retain your right to enroll at a later date if you are covered as an employee or as a dependent of your spouse, civil union partner, or same-sex domestic partner in another public or private employer group health plan. You will retain your right to enroll in the Retired Group when your coverage with the other employer terminates, provided that you complete an online enrollment through Benefitsolver, along with proof of other coverage within 60 days that the coverage is lost.
- If you are otherwise eligible for enrollment under the provisions of P.L. 1997, c. 330 (Chapter 330), you must waive coverage if you have other coverage through active employment after retirement. You will retain your right to enroll in the Retired Group when your coverage terminates with the other employer, provided that you complete an online enrollment through Benefitsolver within 60 days of the loss of coverage
- If you are a JRS member eligible to file for a Deferred Retirement under the provisions of P.L. 2019, c. 287 (Chapter 287), you must waive your retired coverage to obtain active coverage through employment as the county prosecutor. You will retain your right to enroll in the Retired Group when your coverage terminates with the county. Submit an online enrollment through Benefitsolver within 60 days of the loss of coverage.

Limitations on Enrolling Dependents

Eligible dependents can be added to Retired Group coverage upon initial enrollment of the retiree and within 60 days of a change of family status (marriage, civil union, same-sex domestic partnership, birth of child, etc.) that made the dependent eligible. The family member will be enrolled retroactive to the date of eligibility. An online enrollment through Benefitsolver plus required supporting documentation (marriage certificate, civil union/domestic partnership certificate, birth certificate, proof of dependency, etc.) must be submitted within the 60 days (see the "Required Documentation for Dependent Eligibility and Enrollment" section).

If the online enrollment to add a spouse, civil union partner, same-sex domestic partner, or dependent is not completed within 60 days of the status change (or required documentation is not provided), there will be a minimum two-month waiting period from the date the enrollment is entered into Benefitsolver until the member is covered — beginning the first of the month following the expiration of the waiting period. You may remove family members from coverage at any time. Decreases in coverage will be processed on a timely basis. It is your responsibility to notify the Health Benefits Bureau of the NJDPB of any change in family status by submitting the applicable information online through Benefitsolver. If family members are not properly enrolled, claims will not be paid.

Change of Coverage

To change Retired Group coverage you must submit an online enrollment through Benefitsolver, accessible via your myNewJersey account or at mynjbenefitshub.nj.gov

There is no specific Open Enrollment period for Retired Group members. A retiree can switch medical plans once in any 12-month period or when rates change.

Retirees are also eligible and should change coverage under the following circumstances:

- You marry and want to enroll your spouse. Photocopies of the marriage certificate and additional supporting documentation are required for enrollment;
- You need to enroll an eligible civil union or same-sex domestic partner and/or newly eligible children. A photocopy of the *New Jersey Civil Union Certificate, Certificate of Domestic Partnership*, and/or birth certificates for any children, and all required supporting documentation must be uploaded into Benefitsolver (may not apply to all employees, see the "Eligible Dependents" section for additional information about eligible same-sex domestic partners);
- You need to enroll a new child. Photocopies of the child's birth certificate and any additional supporting documentation are required;
- You have a change in family status involving the loss of eligibility of a family member (separation; divorce; dissolution of a civil union or same-sex domestic partnership; death). Dependent children are automatically terminated as of the end of the year they attain age 26 and do not require the completion of an application to decrease coverage; or
- Your spouse/partner's employment status changes resulting in a significant change in health coverage.

Note: Retirees should immediately notify the Health Benefits Bureau of changes in family status by submitting the change of status online through Benefitsolver.

Effective Dates

You are responsible for providing Benefitsolver with the required information regarding a coverage change due to death, divorce, or dissolution of a civil union or domestic partnership. The effective date is the first day of the month following the date of death, divorce, or dissolution. Any claims incurred or services provided after this date are ineligible for payment.

End of Coverage

Your coverage under the Retired Group terminates if:

- You submit a request to cancel through Benefitsolver;
- Your retirement is canceled;
- Your pension allowance is suspended;
- You do not pay your required premiums;
- You or your spouse/partner do not provide proof of enrollment in Medicare Part A and Part B when eligible for Medicare coverage or your Medicare coverage ends;
- Your former employer withdraws from the SHBP or SEHBP (this may not apply to certain retirees of education, police, and fire employers);
- You die (dependent coverage terminates the 1st of the month following the date of death); or
- The SHBP or SEHBP is discontinued.

Survivor Coverage

If you, the retired member, predecease your covered spouse/partner and/or other covered eligible dependents, your surviving dependents may be eligible for continued coverage. It is imperative that survivors notify the NJDPB as soon as possible after your death because their dependent coverage terminates the first of the month following the date of your death. Surviving dependents are generally notified of their rights to continued coverage at the time the NJDPB is notified of the death of the retiree.

MEDICARE FOR RETIREES

Important: A Retired Group member and/or dependent spouse, civil union partner, same-sex domestic partner, or child who is eligible for Medicare coverage by reason of age or disability must be enrolled in both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to enroll or remain in Retired Group coverage.

New retirees or spouses/partners who are enrolled in Medicare Part A and Part B will be required to enter evidence of enrollment in Benefitsolver. Members must enter their Medicare Beneficiary Identification number (MBI). Failure to provide your MBI will result in termination of your coverage. To reinstate coverage you will be required to send acceptable documentation to the Division. Acceptable documentation includes a photocopy of the Medicare card showing both Part A and Part B enrollment or a letter from Medicare indicating the effective dates of both Part A and Part B coverage, and MBI. Send your evidence of enrollment to the New Jersey Division of Pensions & Benefits, Health Benefits Bureau, P.O. Box 299, Trenton, NJ 08625-0299 or fax it to (609) 341-3407.

If you and/or your spouse/partner are eligible for Medicare and do not submit proof of enrollment, you will not be enrolled in an SHBP/SEHBP Retired Group plan until proof is received.

Retirees and/or spouses/partners who are enrolled in the SHBP/SEHBP Retired Group and later become eligible for Medicare Part A and Part B do not need to provide proof of enrollment. The Centers for Medicare and Medicaid Services (CMS) will notify the Health Benefits Bureau directly.

Note: If a provider is not registered with or opts out of Medicare, no benefits are payable under the SHBP/SEHBP for the provider's services, the charges will not be considered under the medical plan, and the member will be responsible for the charges.

Medicare Part A and Part B Eligibility

In most cases, Retired Group members and/or dependents should enroll in Medicare Part A and Part B coverage as soon as they become eligible. Otherwise, individuals can only enroll during Medicare's annual General Enrollment Period (January 1 through March 31) and late enrollment penalties may apply (visit ***www.medicare.gov*** or contact Medicare at 1-800-633-4227 for more information).

Members may be eligible for Medicare for the following reasons:

- **Medicare Eligibility by Reason of Age**

  Members (retirees or covered spouses/partners) are considered to be eligible for Medicare by reason of age from the first day of the month during which they reach age 65. However, if they are born on the first day of a month, they are considered to be eligible for Medicare from the first day of the month which is immediately prior to their 65th birthday.

- **Medicare Eligibility by Reason of Disability**

  Members (retirees or covered spouses/partners/dependents) who are under age 65 are considered to be eligible for Medicare if they have been receiving Social Security Disability benefits for 24 months.

- **Medicare Eligibility by Reasons of End Stage Renal Disease**

  Members (retirees or covered spouses/partners/dependents) who are not eligible for Medicare because of age or disability may qualify because of treatment for End Stage Renal Disease (ESRD).

When a person is eligible for Medicare due to ESRD, Medicare is the secondary payer when:

— The individual has group health coverage of his/her own or through a family member (including a spouse); and

— The group health coverage is from either a current employer or a former employer. The employer may be of any size (not limited to employers with more than 20 employees).

The rules listed above, known as the Medicare Secondary Payer (MSP) rules, are federal regulations that determine whether Medicare pays first or second to the group health plan. These rules have changed over time.

Currently, where the member becomes eligible for Medicare solely on the basis of ESRD, the Medicare eligibility can be segmented into three parts: (1) an initial three-month waiting period; (2) a coordination of benefits period; and (3) a period where Medicare is primary:

— Three-month waiting period (see **"Note"**)

Once a person has begun a regular course of renal dialysis for treatment of ESRD, there is a three-month waiting period before the individual becomes entitled to Medicare Part A and Part B benefits. During the initial three-month period, the group health plan is primary.

— Coordination of benefits period (see **"Note"**)

During the coordination of benefits period, Medicare is secondary to the group health plan coverage. Claims are processed first under the health plan, and Medicare considers the claims as a secondary carrier. For members who became eligible for Medicare due solely to ESRD, the coordination of benefits period is 30 months.

— When Medicare is primary (see **"Note"**)

After the coordination of benefits period ends, Medicare is considered the primary payer and the group health plan is secondary. If you are eligible for Medicare by reason of ESRD and Medicare is primary, you must enroll in Medicare A and B and submit proof of enrollment to the SHBP/SEHBP. If you do not enroll in Medicare A and B before the end of the coordination of benefits period, your SHBP/SEHBP coverage will be terminated. It is your responsibility to ensure that you file your application for Medicare so that the Medicare effective date is on or before the date that the coordination of benefits period ends.

Note: If you are a Medicare Advantage member, some of these scenarios do not apply. Once your three-month waiting period ends and you become eligible for Medicare, you will be enrolled in the Medicare Advantage Plan, which pays primary to Medicare.

Dual Medicare Eligibility

When the member is eligible for Medicare because of age or disability and then becomes eligible for Medicare because of ESRD:

- If the health plan is primary because the member has active employment status, then the group health plan continues to be primary for 30 months from the date of dual Medicare entitlement.
- If the health plan is secondary because the member is not actively employed, then the health plan continues to be the secondary payer. There is no 30-month coordination period.

How to File a Claim If You Are Eligible for Medicare[1]

When filing your claim, follow the procedure listed below that applies to you.

New Jersey Physicians or Providers:

- You should provide the physician or provider with your identification number. This number is indicated on the *Medicare Request for Payment* (claim form) under "Other Health Insurance."
- The physician or provider will then submit the *Medicare Request for Payment* to the Medicare Part B carrier.
- After Medicare has taken action, you will receive an *Explanation of Benefits* statement from Medicare.
- If the remarks section of the *Explanation of Benefits* contains the following statement, you need not take any action: "This information has been forwarded to (name of your plan) for their consideration in processing supplementary coverage benefits."
- If the statement shown above does not appear on the *Explanation of Benefits,* you should indicate your Social Security number and the name and address of the physician or provider in the remarks section of the *Explanation of Benefits* with a completed claim form and send it to the address on the claim form of your plan.

[1]*Does not apply to Medicare Advantage Plans.*

Out-Of-State Physicians or Providers:

- The *Medicare Request for Payment Form* should be submitted to the Medicare Part B carrier in the area where services were performed. Call your local Social Security office for information.
- When you receive the *Explanation of Benefits*, indicate your identification number and the name and address of the physician or provider in the remarks section and send the *Explanation of Benefits* with a completed claim form to the address on the claim form.

Medicare Part D

If you are enrolled in the Retired Group of the SHBP/SEHBP and eligible for Medicare, you will be automatically enrolled in Medicare Part D and the OptumRx Medicare Prescription Drug Plan (PDP), unless your employer opted out of the SHBP/SEHBP Rx Plan.

Note: If you decide not to be enrolled in the OptumRx PDP, you will lose your prescription drug benefits provided by the SHBP/SEHBP, however, your medical benefits will continue. If you are enrolled in an MA plan, your health benefits will terminate as well as the Rx. In order to waive the OptumRx Medicare PDP, you must enroll in another Medicare Part D Plan. To request that you not be enrolled, you must submit proof of enrollment in another Medicare Part D plan.

If you have waived your prescription drug coverage for another Medicare Part D plan, and you wish to re-enroll in the OptumRX Medicare PDP, you must send proof of your termination from the other Medicare Part D plan. Acceptable proof is a letter confirming the date upon which you are disenrolled from the other Medicare Part D plan. We must receive this proof within 60 days of the termination from the other Medicare Part D plan.

COBRA COVERAGE

Continuing Coverage When It Would Normally End

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federally regulated law that gives employees and their eligible dependents the opportunity to remain in their employer's group coverage when they would otherwise lose coverage because of certain qualifying events. In addition, certain members who lose their Retired Group coverage are allowed to continue coverage under COBRA. COBRA coverage is available for limited time periods (see the "Duration of COBRA Coverage" section), and the member must pay the full cost of the coverage plus an administrative fee.

Leave taken under the federal and/or State Family Leave Act is not subtracted from your COBRA eligibility period.

Under COBRA, you may elect to enroll in any or all of the coverages you had as an active employee or dependent (health, prescription, and dental), and you may change your health or dental plan when enrolling in COBRA. You may also elect to cover the same dependents that you covered while an active employee, or delete dependents from coverage; however, you cannot add dependents who were not covered while an employee except during the annual Open Enrollment period (see below) or unless a qualifying event (marriage, civil union, birth or adoption of a child, etc.) occurs and you notify the COBRA administrator within 60 days of the COBRA event.

Open Enrollment — COBRA enrollees have the same rights to coverage at Open Enrollment as are available to active employees. This means that you or a dependent who elected to enroll under COBRA are able to enroll in any SHBP/SEHBP medical coverage for which you are eligible and, if offered by your employer, State prescription drug and/or employee dental plan coverage during the Open Enrollment period, regardless of whether you elected to enroll for the coverage when you first enrolled under COBRA. However, any time of non-participation in the benefit is counted toward your maximum COBRA coverage period. If plan changes occur to the health insurance package available to active employees and retirees, those changes apply equally to COBRA participants.

COBRA Events

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

- Termination of employment (except for gross misconduct);
- Death of the member;
- Reduction in work hours;
- Leave of absence;
- Divorce, legal separation, dissolution of a civil union or same-sex domestic partnership (makes spouse/partner and/or stepchildren ineligible for further dependent coverage);
- Loss of a dependent child's eligibility through the attainment of age 26; or
- The employee elects Medicare as primary coverage (federal law requires active employees to terminate their employer's health coverage if they want Medicare as their primary coverage).

The occurrence of the COBRA event must be the reason for the loss of coverage for you or your dependent to be able to take advantage of the provisions of the law. If there is no coverage in effect at the time of the event, there can be no continuation of coverage under COBRA. Continuation of group coverage under COBRA is not permitted for an over age child who loses coverage under Chapter 375 (see the "Eligible Dependents" section).

Cost of COBRA Coverage

If you choose to purchase COBRA benefits, you pay 100 percent of the cost of the coverage plus a two percent charge for administrative costs (the charge is included in the rate charts).

Duration of COBRA Coverage

COBRA coverage may be purchased for up to 18 months if you or your dependents 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 you have a Social Security Administration-approved disability (under Title II or XVI of the Social Security Act) for a condition that existed when you enrolled in COBRA or began within the first 60 days of COBRA coverage. Coverage will cease either at the end of your COBRA eligibility or when you obtain 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 your death, divorce, dissolution of a civil union or same-sex domestic partnership, or a child attaining age 26, or because you elected Medicare as your primary coverage.

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.

Employer Responsibilities Under COBRA

The COBRA law requires employers to:

- Notify you and your dependents of the COBRA provisions within 90 days of when you and your dependents are first enrolled;
- Notify you, your spouse/partner, and your children of the right to purchase continued coverage within 14 days of receiving notice that there has been a COBRA-qualifying event that causes a loss of coverage;
- Send the *COBRA Notification Letter* and instructions regarding how to enroll in COBRA online through Benefitsolver within 14 days of receiving notice that a COBRA-qualifying event has occurred;
- Notify the NJDPB within 30 days of the loss of an employee's coverage; and
- Maintain records documenting their compliance with the COBRA law.

Employee Responsibilities Under COBRA

The law requires that you and your dependents:

- Notify your employer (if you are retired, you must notify the Health Benefits Bureau of the NJDPB) that a divorce, dissolution of a civil union or same-sex domestic partnership, or death has occurred. Notification must be given within 60 days of the date the event occurred by entering the qualifying event into Benefitsolver (dependent children are automatically terminated as of the end of the year they attain age 26 and do not require the completion of an application to decrease coverage);
- Enroll in COBRA via Benefitsolver within 60 days of the loss of coverage or the date of the *COBRA Notice* provided by your employer, whichever is later;
- Businessolver will mail a paper application to dependents to complete and return for processing in Benefitsolver.
- Pay the required monthly premiums in a timely manner; and
- Pay premiums, when billed, retroactive to the date of group coverage termination.

Failure to Elect COBRA Coverage

In considering whether to elect continuation of coverage under COBRA, an eligible employee, retiree, or dependent (also known as a qualified beneficiary under COBRA law) should take into account that a failure to continue group health coverage will affect future rights under federal law.

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

Termination of COBRA Coverage

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

- Your eligibility period expires;
- You fail to pay your premiums in a timely manner;
- After the COBRA event, you become covered under another group insurance program;

- You voluntarily cancel your coverage;
- Your employer drops out of the SHBP/SEHBP; or
- You become eligible for Medicare after you elect COBRA coverage (this affects health insurance only; not dental or prescription coverage).

SPECIAL PLAN PROVISIONS

Women's Health and Cancer Rights Act

The SHBP/SEHBP adheres to the federal mandate – the Women's Health and Cancer Rights Act of 1998. The mandate requires that plans which cover mastectomies must cover breast reconstruction surgery to produce a symmetrical appearance, prostheses, and treatment of any physical complications.

Automobile-Related Injuries

The Programs will provide secondary coverage to Personal Injury Protection (PIP) unless you choose your medical plan as your primary insurer on your automobile policy. In addition, if your automobile policy contains provisions that make PIP secondary or as excess coverage to your medical plan, then the SHBP or SEHBP will automatically be primary to your PIP policy. If you elect your medical plan as primary, this election may affect each of your family members differently.

When the SHBP or SEHBP is primary to your PIP policy, benefits are paid in accordance with the terms, conditions, and limits set forth by the medical plan you have chosen. For example, if you are enrolled in an HMO you would need referrals from your PCP, precertifications, preauthorizations, etc., just as you would for any other treatment to be covered. Your PIP policy would be a secondary payer to whom you would submit any bills unpaid by your plan. Any portions of unpaid bills would be eligible for payment under the terms and conditions of your PIP policy.

Note: If you are covered by the Retired Group and Medicare is primary for you and/or your spouse/partner, you do not have the option to select the SHBP or SEHBP as primary to your PIP policy.

If your SHBP or SEHBP plan is secondary to the PIP policy, the actual benefits payable will be the lesser of:

- The remaining uncovered allowable expenses after the PIP policy has provided coverage. The expenses will be subject to medical appropriateness and any other provisions of your SHBP or SEHBP plan, after application of any deductibles and coinsurance; or
- The actual benefits that would have been payable had your SHBP or SEHBP plan been primary to your PIP policy.

If you are enrolled in several health plans regardless of whether you have selected PIP as your primary or secondary coverage, the plans will coordinate benefits as dictated by each plan's coordination of benefits terms and conditions. You should consult the coordination of benefits provisions in your plan's guidebook and your PIP policy to assist you in making this decision.

Work-Related Injury or Disease

Work-related injuries or disease are not covered under the SHBP or SEHBP. This includes the following:

- Injuries arising out of or in the course of work for wage or profit, whether or not you are covered by a Workers' Compensation policy.
- Disease caused by reason of its relation to Workers' Compensation law, occupational disease laws, or similar laws.
- Work-related tests, examinations, or immunizations of any kind required by your work.

Note: If you collect benefits for the same injury or disease from both Workers' Compensation and the SHBP or SEHBP, you may be subject to prosecution for insurance fraud.

Mental Health Parity Act Requirements

The SHBP and SEHBP currently meet the federal requirement that all mental health illnesses be covered the same as any other illness, subject to medical necessity.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires group health plans to implement several provisions contained within the law or notify its membership each plan year of any provisions from which they may file an exemption. Self-funded, non-federal government plans may elect certain exemptions from compliance with HIPAA provisions on a year-to-year basis.

Certification of Coverage

HIPAA rules state that if a person was previously covered under another group health plan, that coverage period will be credited toward any pre-existing condition limitation period for the new plan. Credit under this plan includes any prior group plan that was in effect 90 days prior to the individual's effective date under the new plan. A *Certification of Coverage* form, which verifies your group health plan enrollment and termination dates, is available through your payroll or human resources office, should you terminate your coverage.

HIPAA Privacy

The Programs make every effort to safeguard the health information of their members and comply with the privacy provisions of HIPAA, which require that health plans maintain the privacy of any personal information relating to a member's physical or mental health. See the "Notice of Privacy Practices to Enrollees" section.

NOTICE OF PROVIDER TERMINATION

Any person enrolled in an HMO or Tiered Network plan must be provided 90-days notice if that person's PCP will be terminated from the provider network. If 90-day notice cannot be provided, the plan must notify the member as soon as possible. The covered person may then choose another PCP or may change coverage to another participating medical plan.

MEDICAL PLAN EXTENSION OF BENEFITS

If you are totally disabled with a condition or illness at the time of your termination from the SHBP or SEHBP and you have no other group medical coverage, you may qualify for an extension of benefits for this specific condition or illness. To obtain more information about total disability and the extension of benefits, please contact your medical plan's claims administrator for assistance.

If the extension applies, it is only for expenses relating to the disabling condition or illness. An extension, under any plan, will be for the time a member remains disabled from any such condition or illness, but not beyond the end of the calendar year after the one in which the person ceases to be a covered person. During an extension there will be no automatic restoration of part or all of a lifetime benefit maximum.

AUDIT OF DEPENDENT COVERAGE

Periodically, the NJDPB performs an audit using a sample of members to determine if enrolled dependents are eligible under plan provisions. Proof of dependency such as a marriage, civil union, or birth certificates, or tax returns are required. Coverage for ineligible dependents will be terminated. Failure to respond to the audit will result in the termination of all coverage and may include financial restitution for claims paid. Members who are found to have intentionally enrolled an ineligible person for coverage will be prosecuted to the fullest extent of the law.

HEALTH CARE FRAUD

Health care fraud is an intentional deception or misrepresentation that results in an unauthorized benefit to a member or to some other person. Any individual who willfully and knowingly engages in an activity intended to defraud the SHBP or SEHBP will face disciplinary action that could include termination of employment and may result in prosecution. Any member who receives monies fraudulently from a health plan will be required to fully reimburse the plan.

APPENDIX

CLAIM APPEAL PROCEDURES

MEDICAL APPEALS

Medical, Dental, and Prescription Drug Plans

Appeals for SHBP/SEHBP members that question an adverse determination involving medical judgment are considered Medical Appeals.

Examples of Medical Appeals include the denial of a service(s) for:

- Cosmetic reasons;
- Medical necessity;
- Being considered experimental/investigational; or
- Not meeting policy criteria.

Medical appeals have a two-level internal appeal process followed by an external appeal. The first two levels of appeal are conducted through your medical, dental, or prescription drug plan. A first-level appeal must be submitted within one year (180 days for HMOs) following your receipt of the plan's initial adverse benefit determination. Consult the appropriate member guidebook for specific instructions on filing these types of appeals.

Once the two levels of appeal are exhausted with the medical, dental, or prescription drug plans, you will have the option of filing a third-level appeal.

Medical Appeals and Administrative Prescription Plan Appeals, except for dental appeals, may be requested through your medical or prescription drug plan. Third-level dental appeals will be heard by the SHBC/SEHBC. Appeal requests for an Independent Review Organization (IRO) review must be submitted within four months from your receipt of the medical or prescription plan's final determination. The IRO will provide a final review decision within 45 days after the IRO receives the complete appeal file. The IRO decision will be binding upon the medical or prescription plan.

ADMINISTRATIVE APPEALS

Medical and Dental Plans

Appeals for SHBP/SEHBP members that question an adverse determination involving benefit limits, exclusions, or contractual issues are considered Administrative Appeals. Administrative Appeals must be submitted within one year following your receipt of the initial adverse benefit determination. Administrative Appeals might also question enrollment, eligibility, or plan benefit decisions such as whether a particular service is covered or paid appropriately.

Examples of Administrative Appeals are:

- Visits beyond the 30-visit chiropractic limit;
- Benefits beyond the Reasonable & Customary Allowance;
- Routine vision services rendered out-of-network;
- Benefits for a wig that exceed the $500/24-month limit; or
- Dispensing limits of a prescription drug.

The member or member's legal representative must appeal in writing to the SHBC/SEHBC. If the member is deceased or incapacitated, the individual legally entrusted with his or her affairs may act on the member's behalf.

Request for SHBC/SEHBC consideration must contain the reason, in detail, for the disagreement along with copies of all relevant correspondence and should be directed to:

State Health Benefits Commission or
School Employees' Health Benefits Commission
Appeals Coordinator
P.O. Box 299
Trenton, NJ 08625-0299

Notification of all SHBC/SEHBC decisions will be made in writing to the member. If the SHBC/SEHBC denies the member's appeal, the member will be informed of further steps that may be taken in the denial letter from the SHBC/SEHBC. Any member who disagrees with the SHBC/SEHBC's decision may request in writing to the SHBC/SEHBC, within 45 days, that the case be forwarded to the Office of Administrative Law (OAL). The SHBC/SEHBC will then determine if a factual hearing is necessary. If so, the case will be forwarded to the OAL. An Administrative Law Judge will hear the case and make a recommendation to the SHBC/SEHBC, which the SHBC/SEHBC may adopt, modify, or reject. If the recommendation is rejected, the administrative appeal process is ended. When the administrative process is ended, further appeals will be made to the Superior Court of New Jersey Appellate Division.

If your case is forwarded to the OAL, you will be responsible for the presentation of your case and for submitting all evidence. You will be responsible for any expenses involved in gathering evidence or material that will support your grounds for appeal. You will be responsible for any court filing fees or related costs that may be necessary during the appeal process. If you require an attorney or expert medical testimony, you will be responsible for any fees or costs incurred. Note that charges for experts retained by the health plan to conduct the external review of an adverse benefit determination (or the IRO with which the plan contracts to conduct the external review), are not borne by the member.

HMO PLAN STANDARDS

Minimum coverage requirements and operating standards are established for all participating HMOs to safeguard members and make it easier to compare and choose between plans. The following is not a benefit summary but a listing of benefit coverage for which mandatory expectations or requirements are imposed.

Standards Include:

- All physician referrals will be valid for a minimum of 90 days from the date of authorization;
- Certain treatments requiring numerous visits (e.g., chemotherapy) shall not require repeated referrals;
- A *Schedule of Benefits* which will provide a list of covered services, benefit limitations and benefit exclusions, and appropriate definitions, which is available on our website;
- The HMO will notify the State and members prior to any proposed changes in the provider network, including facilities, that alter member access to providers or services;
- There shall be no pre-existing condition restrictions;
- Network within network referral restrictions will not be permitted;
- Right to change PCPs must be permitted on at least a monthly basis;
- Scope of services covered under the well-woman OB/GYN provisions must be clearly defined, including the explicit services which must be authorized by the member's PCP. It is required that two or more well-woman OB/GYN examinations be available during the Benefit Plan Year, and that a well-woman mammogram not require a PCP authorization;
- HMO members must be permitted to self-refer to network mental health and substance abuse practitioners; and
- Extension of health benefits must be made at no cost to totally disabled members who do not elect COBRA coverage and to those whose coverage terminates at the end of the COBRA-continuation period including cessation of premium payments. The extension is made available to those members who are totally disabled on the date their coverage terminates and need not require hospital confinement, and is only applicable to expenses incurred in the treatment of the disabling condition. The extension period will end on the earliest of:
  - — the date the total disability ends;
  - — the end of the calendar year after the one in which the person ceases to be a covered person;
  - — the date the person has received the maximum benefits under the HMO plan for the disabling condition; or
  - — the date that the person becomes covered under any replacement plan established by the employer.

Emergency

The following definition for emergency care will be adhered to by all plans:

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

The copayment for emergency room services will be waived if admitted.

With respect to emergency services furnished in a hospital emergency department, a health plan shall not require prior authorization for the provision of such services if the member arrived at the emergency medical department with symptoms that reasonably suggested an emergency condition based on the judgment of a prudent layperson, regardless of whether the hospital was affiliated with the HMO. All procedures performed during the evaluation (triage) and treatment of an emergency medical condition shall be covered by the HMO.

Minimum Coverage Requirements

Benefit standards include:

- Routine office visit copayments;
- All plans will cover chiropractor visits up to a maximum of 20 visits per calendar year;
- Hair prosthesis furnished in connection with hair loss resulting from the treatment of disease by radiation or chemicals will be covered ($500 maximum);
- Routine inoculations for adults (not related to travel or occupation) will be covered;
- The cost of care to organ transplant donors will be covered (coordination of benefits will apply);
- Admissions at skilled nursing homes will be covered up to 120 days per calendar year;
- Hospice services will be covered in full;

- Home health care will be covered up to a maximum of 120 visits per calendar year;
- Provided all medical eligibility criteria are met, outpatient therapy will be covered up to 60 visits per condition per calendar year;
- Repair and replacement of prosthesis will be covered;
- Surgical leggings, ostomy supplies, and foot orthotics will be covered if medically necessary; and
- There will be no reimbursement for vision hardware.

Mental Health and Alcohol/Substance Abuse

- All plans will use standard treatment criteria established by the American Society of Addictive Medicine (ASAM); and
- Mental heath conditions are treated like any other illness.

NEW JERSEY HEALTH CARE PERFORMANCE REPORTS

New Jersey HMO Performance Report: Compare Your Choices

You can compare quality ratings of various HMOs with the New Jersey Department of Banking and Insurance's *New Jersey HMO Performance Report: Compare Your Choices*.

To obtain a copy of the latest *New Jersey HMO Performance Report: Compare Your Choices*, contact the New Jersey Department of Banking and Insurance, Division of Insurance, P.O. Box 325, Trenton, NJ 08625-0325, or call 1-800-446-7467. The report is also available online at: ***www.state.nj.us/dobi***

New Jersey Hospital Performance Report

Available at the Department of Health website is the *New Jersey Hospital Performance Report* that contains information on the performance of all New Jersey acute care hospitals for two types of conditions — heart attack and pneumonia. Visit the Department of Health and Senior Services online at: ***www.nj.gov/health***

NOTICE OF PRIVACY PRACTICES TO ENROLLEES

Protected Health Information (PHI)

The Programs are required by the federal HIPAA and State laws to maintain the privacy of any information that is created or maintained by the Programs that relates to your past, present, or future physical or mental health. This PHI includes information communicated or maintained in any form. Examples of PHI are your name, address, Social Security number, birth date, telephone number, fax number, dates of health care service, diagnosis codes, and procedure codes. PHI is collected by the Programs through various sources, such as enrollment forms, employers, health care providers, federal and State agencies, or third-party vendors.

The Programs are required by law to abide by the terms of this Notice. The Programs reserve the right to change the terms of this Notice. If material changes are made to this Notice, a revised Notice will be sent.

Uses and Disclosures of PHI

The Programs are permitted to use and to disclose PHI in order for our members to obtain payment for health care services and to conduct the administrative activities needed to run the Programs without specific member authorization. Under limited circumstances, we may be able to provide PHI for the health care operations of providers and health plans. Specific examples of the ways in which PHI may be used and disclosed are to follow. This list is illustrative only and not every use and disclosure in a category is listed.

- The Programs may disclose PHI to a doctor or a hospital to assist them in providing a member with treatment.
- The Programs may use and disclose member PHI so that our Business Associates may pay claims from doctors, hospitals, and other providers.
- The Programs receive PHI from employers, including the member's name, address, Social Security number, and birth date. This enrollment information is provided to our Business Associates so that they may provide coverage for health care benefits to eligible members.
- The Programs and/or our Business Associates may use and disclose PHI to investigate a complaint or process an appeal by a member.
- The Programs may provide PHI to a provider, a health care facility, or a health plan that is not our Business Associate that contacts us with questions regarding the member's health care coverage.
- The Programs may use PHI to bill the member for the appropriate premiums and reconcile billings we receive from our Business Associates.
- The Programs may use and disclose PHI for fraud and abuse detection.
- The Programs may allow use of PHI by our Business Associates to identify and contact our members for activities relating to improving health or reducing health care costs, such as information about disease management programs or about health-related benefits and services or about treatment alternatives that may be of interest to them.
- In the event that a member is involved in a lawsuit or other judicial proceeding, the Programs may use and disclose PHI in response to a court or administrative order as provided by law.
- The Programs may use or disclose PHI to help evaluate the performance of our health plans. Any such disclosure would include restrictions for any other use of the information other than for the intended purpose.
- The Programs may use PHI in order to conduct an analysis of our claims data. This information may be shared with internal departments such as auditing or it may be shared with our Business Associates, such as our actuaries.

Except as described above, unless a member specifically authorizes us to do so, the Programs will provide access to PHI only to the member, the member's authorized representative, and those organizations who need the information to aid the Programs in the conduct of its business (our Business Associates). An authorization form may be obtained on our website. A member may revoke an authorization at any time.

Restricted Uses

- PHI that contains genetic information is prohibited from use or disclosure by the Programs for underwriting purposes.
- The use or disclosure of PHI that includes psychotherapy notes requires authorization from the member.

When using or disclosing PHI, the Programs will make every reasonable effort to limit the use or disclosure of that information to the minimum extent necessary to accomplish the intended purpose. The Programs maintain physical, technical and procedural safeguards that comply with federal law regarding PHI. In the event of a breach of unsecured PHI the member will be notified.

Member Rights

Members of the Programs have the following rights regarding their PHI:

Right to Inspect and Copy: With limited exceptions, members have the right to inspect and/or obtain a copy of their PHI that the Programs maintain in a designated record set which consists of all documentation relating

to member enrollment and the Programs' use of this PHI for claims resolution. The member must make a request in writing to obtain access to their PHI. The member may use the contact information found at the end of this Notice to obtain a form to request access.

Right to Amend: Members have the right to request that the Programs amend the PHI that we have created and that is maintained in our designated record set.

We cannot amend demographic information, treatment records, or any other information created by others. If members would like to amend any of their demographic information, they should contact their personnel office. To amend treatment records, a member must contact the treating physician, facility, or other provider that created and/or maintains these records.

The Programs may deny the member's request if: 1) we did not create the information requested on the amendment; 2) the information is not part of the designated record set maintained by the Programs; 3) the member does not have access rights to the information; or 4) we believe the information is accurate and complete. If we deny the member's request, we will provide a written explanation for the denial and the member's rights regarding the denial.

Right to an Accounting of Disclosures: Members have the right to receive an accounting of the instances in which the Programs or our Business Associates have disclosed member PHI. The accounting will review disclosures made over the past six years. We will provide the member with the date on which we made a disclosure, the name of the person or entity to whom we disclosed the PHI, a description of the information we disclosed, the reason for the disclosure, and certain other information. Certain disclosures are exempted from this requirement (e.g., those made for treatment, payment or health benefits operation purposes or made in accordance with an authorization) and will not appear on the accounting.

Right to Request Restrictions: The member has the right to request that the Programs place restrictions on the use or disclosure of their PHI for treatment, payment, or health care operations purposes. The Programs are not required to agree to any restrictions and in some cases will be prohibited from agreeing to them. However, if we do agree to a restriction, our agreement will always be in writing and signed by the Privacy Officer. The member request for restrictions must be in writing. A form can be obtained by using the contact information found at the end of this Notice.

Right to Restrict Disclosures: The member has the right to request that a provider restrict disclosure of PHI to the Programs or Business Associates if the PHI relates to services or a health care item for which the individual has paid the provider in full. If payment involves a FSA or HSA, the individual cannot restrict disclosure of information necessary to make the payment but may request that disclosure not be made to another program or health plan.

Right to Receive Notification of a Breach: The member has the right to receive notification in the event that the Programs or a Business Associate discover unauthorized access or release of PHI through a security breach.

Right to Request Confidential Communications: The member has the right to request that the Programs communicate with them in confidence about their PHI by using alternative means or an alternative location if the disclosure of all or part of that information to another person could endanger them. We will accommodate such a request if it is reasonable, if the request specifies the alternative means or locations, and if it continues to permit the Programs to collect premiums and pay claims under the health plan.

To request changes to confidential communications, the member must make their request in writing, and must clearly state that the information could endanger them if it is not communicated in confidence as they requested.

Right to Receive a Paper Copy of the Notice: Members are entitled to receive a paper copy of this Notice. Please contact us using the information at the end of this Notice.

Questions and Concerns

If you have questions or concerns, please contact the Programs using the information listed at the end of this Notice (local county, municipal, and board of education employees should contact the HIPAA Privacy Officer for their employer).

If members think the Programs may have violated their privacy rights, or they disagree with a decision made about access to their PHI, in response to a request made to amend or restrict the use or disclosure of their information, or to have the Programs communicate with them in confidence by alternative means or at an alternative location, they must submit their concern in writing. To obtain a form for submitting a concern, use the contact information found at the end of this Notice.

Members also may submit a written concern to the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201.

The Programs support member rights to protect the privacy of PHI. It is your right to file a concern with the Programs or with the U.S. Department of Health and Human Services.

Contact Office:

The New Jersey Division of Pensions & Benefits
HIPAA Privacy Officer

Address:

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

HEALTH BENEFITS CONTACT INFORMATION

Contact information for medical, dental, and prescription drug plan carriers are as follows:

Aetna Medical and Dental Plans

Medical Plans for Active Employees and Non-Medicare Retirees: 1-877-STATENJ (1-877-782-8365)

Medicare Advantage for SHBP retirees: 1-866-234-3129

Medicare Advantage for SEHBP retirees: 1-866-816-3662

Dental Plans for Active Employees and Retirees: 1-877-STATENJ (1-877-782-8365)

Horizon Medical and Dental Plans

Medical Plans for Active Employees and Non-Medicare Retirees: 1-800-414-7427

Dental Plans for Active Employees and Retirees: 1-833-597-7427

OptumRx Prescription Plans

Active Employees: 1-844-368-8740

Medicare Retirees: 1-844-368-8765

Addresses

Our mailing address is:

New Jersey Division of Pensions & Benefits
P.O. Box 299
Trenton, NJ 08625-0299

Our website address is:

www.nj.gov/treasury/pensions

Our email address is:

pensions.nj@treas.nj.gov

Telephone Numbers

NJDPB:Office of Client Services . . . . .(609) 292-7524

TDD Phone
(Hearing Impaired). . . . . TRS 711 (609) 292-6683

State Employee Advisory
Service (EAS) 24 hours a day 1-866-EAS-9133
1-866-327-9133

New Jersey State Police Employee
Advisory Program (EAP) 1-800-FOR-NJSP

Rutgers University
Behavioral Health Care
Employee Advisory Program (EAP) . 1-800-327-3678

New Jersey Department of
Banking and Insurance
Individual Health Coverage
Program Board 1-800-838-0935

Consumer Assistance for
Health Insurance . . . . . (609) 292-5316 (Press 2)

New Jersey Department of
Human Services
Pharmaceutical Assistance to the
Aged and Disabled (PAAD). 1-800-792-9745

New Jersey Department of Health
Division of Aging and
Community Services 1-800-792-8820

Centers for Medicare and
Medicaid Services
Medicare Part A and Part B. 1-800-MEDICARE

HEALTH BENEFITS PUBLICATIONS

The publications and fact sheets available from the NJDPB provide information on a variety of subjects. Fact sheets, guidebooks, applications, and other publications are available for viewing or downloading on our website.

State of New Jersey
Department of the Treasury
Division of Pensions & Benefits