

NEW JERSEY

**STATE HEALTH BENEFITS PROGRAM
SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM**

***SUMMARY
PROGRAM
DESCRIPTION***

FOR EMPLOYEES AND RETIREES

**Department of the Treasury
Division of Pensions and Benefits**

PLAN YEAR 2012

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INTRODUCTION

The State Health Benefits Program (SHBP) was established in 1961. It offers medical and prescription drug coverage to qualified State and local government public employees, retirees, and eligible dependents; and dental coverage to qualified State and local government/education public employees, retirees, and their 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 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 Division of Pensions and Benefits, specifically the Health Benefits Bureau and the Bureau of Policy and Planning, are responsible for the daily administrative activities of the SHBP and the SEHBP.

The purpose of this *Summary Program Description* is to provide an overview of the plans provided through the SHBP and SEHBP. The individual plan's member handbooks 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 and 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, 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 "Program" will mean both the SHBP and SEHBP unless otherwise indicated.

If, after reading this booklet, you have any questions, comments, or suggestions regarding this material, please write to the Division of Pensions and Benefits, PO Box 295, Trenton, NJ 08625-0295, call us at (609) 292-7524, or send e-mail to: pensions.nj@treas.state.nj.us

Refer to page 76 for additional information on contacting the SHBP, SEHBP, and its related health services.

RECENT BENEFIT CHANGES

CHANGES DUE TO THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)

On March 23, 2010, President Obama signed into law the health care reform bill, the Patient Protection and Affordable Care Act (PPACA). This legislation, along with the Health Care and Education Reconciliation Act of 2010 (Both acts collectively known as federal Health Care Reform (HCR.)), makes sweeping changes to the U.S. health care system. These changes will be implemented over the next several years. Beginning January 1, 2012, the State Health Benefits Program/School Employees' Health Benefits Program (SHBP/SEHBP) will implement changes required by HCR to all plans administered by the Programs.

Preventive Services

Under HCR, certain preventive care, such as immunizations (age and population restrictions may apply), certain age and gender appropriate screenings (blood pressure, cholesterol, depression, newborn, etc.), FDA-approved contraceptive methods and well-baby care, are covered without member cost-sharing. Therefore, primary care well visits (annual exams) will no longer require a copayment or coinsurance by the member.

Note: This applies only when these services are delivered by an in-network provider. Also, if the preventive service is not the primary reason for the office visit, the member remains responsible for a copayment or coinsurance. Contact your medical plan for more information.

Preventive Medications

The following preventive medications are covered with a doctor's prescription with a zero dollar copayment for certain members meeting specific criteria (see the *Prescription Drug Plans Member Handbook* for specific limits related to age, gender, and medical condition): Aspirin, Fluoride, Folic Acid, Iron supplements, and certain drugs that assist with Smoking Cessation.

Children up to Age 26

Children up to age 26 are eligible for coverage as a dependent under their parent even if they are eligible for other employer-based coverage. Previously, the SHBP/SEHBP denied coverage if the child was eligible for other employer-based coverage. A "child" is defined as an enrollee's child until age 26, regardless of the child's marital, student, or financial dependency status — even if the young adult no longer lives with his parents. A *photocopy* of the child's birth certificate that includes the covered parent's name must be submitted along with the application (additional supporting documentation is required for foster or stepchildren).

New Appeals Process Required

Effective January 1, 2012, as required by the federal Patient Protection and Affordable Care Act (PPACA), a new external review process will be implemented for adverse benefit determinations concerning medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. For services obtained prior to January 1, 2012, once the two level carrier appeal process is exhausted, a member can appeal an adverse benefit determination to the State Health Benefits Commission/School Employees' Health Benefits Commission. For services obtained on or after January 1, 2012, if a member is dissatisfied with the results of the two

level carrier appeal process, the next step is to pursue an External Appeal with an independent review organization (IRO). To do so, the member must submit a written request to the carrier within four (4) months from receipt of the carrier's final adverse benefit determination. These procedures may be modified as regulations regarding the external review process are promulgated under the PPACA. Details on appeal procedures are provided in each of the Member Handbooks which are available on the Division of Pensions and Benefits Web site.

CHANGES DUE TO CHAPTER 78, P.L. 2011

Chapter 78, P.L. 2011, established two committees to oversee the benefit design of the plans: one for the State Health Benefits Program (SHBP) and one for the School Employees' Health Benefits Program (SEHBP). The committees are responsible for establishing the design of plans offered by the SHBP and SEHBP.

The State Health Benefits Plan Design Committee is composed of 12 members: six members appointed by the Governor as representatives of public employers whose employees are enrolled in the program; three members appointed by the Public Employee Committee of the AFL-CIO; one member appointed by the head of the union that represents the greatest number of police officers in New Jersey, that is not affiliated with the AFL-CIO; one member appointed by the head of the union that represents the greatest number of firefighters in New Jersey, that is not affiliated with the AFL-CIO; and one member appointed by the head of the State Troopers Fraternal Association.

The School Employees' Health Benefits Plan Design Committee is composed of six members: three members appointed by the Governor as representatives of public employers whose employees are enrolled in the program; two members appointed by the New Jersey Education Association; and one member appointed by the education section of the New Jersey State AFL-CIO.

New Plans

As a result of the Plan Design Committees' actions, new plan choices became available during Open Enrollment with an effective date of coverage of January 1, 2012. The medical plans offered in 2011 remain available and each of the current medical carriers, Horizon Blue Cross Blue Shield of New Jersey, Aetna, and Cigna, have added two new plans that differ in the amount of copayments, deductibles, and out-of-pocket maximums. In addition, each of the three carriers offer two High Deductible Health Plans (HDHP) to State and local government employees and one HDHP to local education employees

Note: Non-Medicare retirees may elect any of the plans offered to active employees with the exception of the HD1500 plans; Medicare eligible retirees cannot enroll in a HDHP plan or in Aetna2030.

Plan Choice

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

Category 1: NJ DIRECT10, NJ DIRECT15, Aetna HMO, Cigna HealthCare HMO

Category 2: NJ DIRECT1525, Aetna1525, Cigna1525

Category 3: NJ DIRECT2030, Aetna2030, Cigna2030

Category 4*: NJ DIRECT HD4000**, NJ DIRECT HD1500, Aetna HD4000**, Aetna HD1500, Cigna HD4000**, Cigna HD1500

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

*Medicare eligible Retirees cannot enroll in a Category 4 plan or Aetna2030.

**HD4000 plans are not offered to SEHBP active employees.

Employee Contributions

New contributions for health benefits were effective immediately (June 28, 2011) for employees whose current contract had expired and employees not covered by a union contract; however, the legislation anticipated that some administrative delay would be unavoidable while payroll systems were modified to accommodate the new contribution requirements. Chapter 78 legislation also provided that once the new contributions were implemented, employers could not recover any uncollected contributions retroactive to the date of enactment.

Most employers are already collecting 1.5% of an employee's salary as a minimum contribution to the cost of health coverage, and this will continue to be the minimum required contribution under the new contribution requirements until the percentage of contribution requirement exceeds the 1.5% of salary amount. (See page 13 for details.)

Retiree Contributions

There are no changes to contributions for current retirees at this time. (See page 16 for details on contributions which will apply to *active employees* who retire.)

IRC Section 125 Plans Required

All local government/education employers are required to offer an IRC Section 125 plan to employees. This will allow employees to make the required premium payments for health care prior to the withholding of taxes. State employees' contributions for health benefits are taken prior to the withholding of taxes under the State's Section 125 plan (Tax\$ave) unless the employee opts out.

Note: The State Tax\$ave Program is not available to local government/education employers. These employers must arrange and provide their own Section 125 plans.

OTHER CHANGES

Prescription Drug Coverage for Medicare Eligible Retirees

Effective January 1, 2012, retired members of the State Health Benefits Program (SHBP) or School Employees' Health Benefits Program (SEHBP) who are eligible for Medicare will be automatically enrolled in Medco's Medicare Part D prescription drug coverage, the **Medco Medicare Prescription Plan**. Medco will remain the prescription drug plan administrator for these retirees and coverage in the Medco Medicare Prescription Drug Plan is similar to the current Medco plans — i.e. members pay the appropriate copayment for either a retail or mail order prescription drug order.

Active Employee Dental Plan

Effective January 1, 2012, the Employee Dental Expense Plan has been changed from a passive Preferred Provider Organization (PPO) benefit design in which employees have the same coinsurance for both in-network and out-of-network providers to a true PPO. The change to a true PPO plan for active employees increases the member share of the coinsurance when using out-of-network providers. If your current dentist is an in-network provider, you will not see any change to your dental benefits. The new PPO plan does not change the current \$50 in-network deductible or \$3,000 benefit maximum.

Dental Expense Plan Benefits Effective January 1, 2012

	In-Network	Out-of-Network
Deductible / Calendar Year	\$50 / Individual \$100 / Family Waived for Preventive Care	\$75 / Individual \$150 / Family Waived for Preventive Care
Coinsurance (as percentage of R&C)	100 % Preventive 80% Basic Restorative 65% Major Restorative 50% Periodontics & Prosthodontics	90% Preventive 70% Basic Restorative 55% Major Restorative 40% Periodontics & Prosthodontics
Maximum Annual Benefit / Individual	\$3,000	\$2,000 (Maximum of \$3,000 combined in and out-of-network)
Orthodontia Under Age 19	50% to \$1,000 lifetime maximum (not subject to deductible) (Maximum not combined with Annual Maximum)	40% to \$750 lifetime (maximum of \$1,000 combined in and out-of-network) (not subject to deductible) (Maximum not combined with Annual Maximum)

HEALTH BENEFITS ELIGIBILITY

ACTIVE EMPLOYEE ELIGIBILITY

Eligibility for coverage is determined by the State Health Benefits Program (SHBP) or School Employees' Health Benefits Program (SEHBP). Enrollments, terminations, changes to coverage, etc. must be presented through your employer to the Division of Pensions and Benefits. If you have any questions concerning eligibility provisions, you should contact the Division of Pensions and Benefits' Office of Client Services at (609) 292-7524.

Any newly appointed or elected officer 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 the local employer or the State 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 a 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 care benefits, but may enroll in the SHBP Retired Group at their own expense provided the employee was covered by the SHBP up to the date of retirement. See Fact Sheet #66, *Health Benefits Coverage for Part-Time Employees*, for details.

State Intermittent Employees — Certain intermittent State employees who have worked 750 hours in a Fiscal Year (July 1 - June 30) will be eligible for NJ DIRECT15 and/or the Prescription Drug Plans. Eligible Intermittents who maintain 750 hours of work per year continue to qualify for health benefits in subsequent years. See Fact Sheet #69, *SHBP Coverage for State Intermittent Employees*, 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 NJ DIRECT15 and the Prescription Drug Plans 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 Division of Pensions and Benefits of members who are eligible.

Fraternal Order of Police and State Police Units — Employees in State law enforcement bargaining units (most Fraternal Order of Police and all State Police units including non-aligned officers) cannot participate in NJ DIRECT10.

Note: This provision does not apply to Fraternal Order of Police employees of Rutgers University, the University of Medicine and Dentistry of New Jersey (UMDNJ), or the New Jersey Institute of Technology (NJIT).

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 or SEHBP. Each participating local employer defines the minimum hours required for full-time by a resolution filed with the Division of Pensions and Benefits, but it can be no less than 25 hours per week or more if required by contract or resolution. 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 a SEHBP medical plan — and if provided by the employer, the Prescription Drug Plans — 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 their own expense provided the faculty member was continuously covered by the SEHBP up to the date of retirement. See Fact Sheet #66, *Health Benefits Coverage for Part-Time Employees*, for details.

ELIGIBLE DEPENDENTS

Your eligible dependents are your spouse, civil union partner, or eligible same-sex domestic partner (as defined below) 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.

Spouse — A member of the opposite sex to whom you are legally married. A photocopy of the 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. 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 Fact Sheet #75, *Civil Unions*, for details).

Domestic Partner — A person of the same sex with whom you have entered into a domestic partnership as defined under Chapter 246, P.L. 2003, 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 ben-

efits, 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 Fact Sheet #71, *Benefits Under the Domestic Partnership Act*, for details).

Children — In compliance with the federal Patient Protection and Affordable Care Act (ACA) and effective with the plan year beginning 2011, coverage is extended for children until age 26. This includes natural children under age 26 regardless of the child's marital, student, or financial dependency status. A photocopy of the child's birth certificate that includes the covered parent's name is required for enrollment.

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 marriage/partnership certificate showing the names of the employee/retiree and spouse/partner.

Foster children, and children in a guardian-ward relationship under age 26 are also eligible. A photocopy of the child's birth certificate **and** additional supporting legal documentation are required with enrollment forms for these cases. Documents must attest to the legal guardianship by the covered employee (see page 71).

Coverage for an enrolled child ends on December 31 of the year in which he or she turns age 26 (see the "COBRA" section on page 57, "Dependent Children with Disabilities" and "Over Age Children Until Age 31" below 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 mental illness, mental retardation, or a physical disability, he or she may be eligible for a continuance of coverage.

To request continued coverage, contact the Office of Client Services at (609) 292-7524 or write to the Division of Pensions and Benefits, Health Benefits Bureau, 50 West State Street, P. O. Box 299, Trenton, New Jersey 08625 for a *Continuance for Dependent with Disabilities* form. The form and proof of the child's condition must be given to the Division 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 *Continuance for Dependent with Disabilities* form. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP or SEHBP, and (2) the child continues to be disabled, and (3) the child is unmarried, and (4) the child remains dependent on you for support and maintenance and lives with you. You will be contacted periodically to verify that the child remains eligible for continued coverage.

Over Age Children Until Age 31 — Certain children over age 26 may be eligible for coverage until age 31 under the provisions of Chapter 375, P.L. 2005, as amended by Chapter 38, P.L. 2008. 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 but is enrolled for coverage in exactly the same plan or plans (medical and/or prescription drug) that the covered parent has selected. 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 when 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 Fact Sheet #74, *Health Benefits Coverage of Children until Age 31 under Chapter 375*, for details.

MEDICARE COVERAGE WHILE EMPLOYED

In general, it is not necessary for a Medicare-eligible employee, spouse, civil union partner, eligible same-sex domestic partner, or eligible 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)** 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 "Medicare Eligibility" beginning on page 52 in the "Retiree Enrollment" section.

RETIREE ELIGIBILITY

The following individuals will be offered 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 life-time annuity immediately following termination of employment.
- Part-time State employees and part-time faculty at institutions of higher education that participate in the SHBP or SEHBP if enrolled in the Program at the time of retirement.
- 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 25 years or more of eligible service credit in one or more State or locally-administered retirement system or who retire on a disability retirement, even if their employer did not cover its employees under the SEHBP. This includes those who elect to defer retirement with 25 or more years of eligible service credit in one or more State or locally-administered retirement system (see *"Aggregate of Pension Membership Service Credit"* on page 11).
- Full-time members of the TPAF and school board or county college employees enrolled in the PERS who retire with less than 25 years of eligible service credit from an employer that participates in the SEHBP.
- Full-time members of the TPAF or PERS who retire from a board of education, vocational/technical school, or special services commission; maintain participation in the health benefits plan of their former employer; and are eligible for and enrolled in Medicare Part A and Part B. A qualified retiree may enroll at retirement or when he or she becomes eligible for Medicare.
- Participants in the Alternate Benefit Program (ABP) who retire with at least 25 years of credited ABP service 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 Fact Sheet #47, *Retired Health Benefits Coverage Under Chapter 330*, for more information.
- Surviving spouses, civil union partners, eligible same-sex domestic partners, and children of Police and Firemen's Retirement System (PFRS) members or State Police Retirement System (SPRS) members killed in the line of duty.

If you allow your active coverage to lapse (i.e. 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 health coverage under the Retired Group. (This does not include full-time TPAF retirees and PERS board of education or county college retirees with 25 or more years of service).

Note: If you continue group coverage through COBRA (see page 57) — or as a dependent under other group coverage through a public or private employer — until your retirement becomes effective, you will be eligible for retired coverage under the SHBP or 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, coverage shall not be retroactive for 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 or SEHBP. An employee of a local government who has 25 years or more of service credit 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 or SEHBP may receive this benefit if the 25 years of service credit is from **one or more** State or locally-administered retirement systems and 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 page 8) except for Chapter 334 domestic partners described below and the Medicare requirements discussed on page 52.

Chapter 334, P.L. 2005, provides that retirees from local entities (municipalities, counties, boards of education, and county colleges) whose employers **do not** participate in the SHBP or SEHBP, but who become eligible for SHBP or SEHBP coverage at retirement (see page 10), 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

The Health Benefits Bureau is notified when you file an application for retirement with the Division of Pensions and Benefits. If eligible, you will receive a letter inviting you to enroll in Retired Group coverage. Early filing for retirement is recommended to prevent any lapse of coverage or delay of eligibility.

If you do not enroll at the time of retirement, you will not generally be permitted to enroll for Retired Group coverage at a later date.

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 Division of Pensions and Benefits, Office of Client Services at (609) 292-7524 or send an e-mail to: pensions.nj@treas.state.nj.us

Additional restrictions and/or requirements may apply when enrolling in the Retired Group. Be sure to read the "Retiree Enrollment" section that begins on page 51 of this booklet.

CHOOSING A MEDICAL PLAN

The SHBP and 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.

AVAILABLE MEDICAL PLANS

The following medical plans* are offered to most State employees**, participating local government and local education employees, and all retirees.

- **NJ DIRECT** — administered by Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) — offers four PPO plans: **NJ DIRECT10**,** **NJ DIRECT15**, **NJ DIRECT1525**, and **NJ DIRECT2030**.
 - **Aetna** and **Cigna** each offer three HMO plans: **Aetna HMO**, **Cigna HealthCare HMO**, **Aetna1525**, **Cigna1525**, **Aetna2030**, and **Cigna2030**.
 - In addition, **NJ DIRECT**, **Aetna**, and **Cigna** each also offer High Deductible Health Plans (HDHP).
 - **State and local government employees** may select from six HDHP choices: **NJ DIRECT HD4000**, **Aetna HD4000**, **Cigna HD4000**, **NJ DIRECT HD1500**, **Aetna HD1500**, and **Cigna HD1500**.
 - **Local education employees** may select from three HDHP choices: **NJ DIRECT HD1500**, **Aetna HD1500**, and **Cigna HD1500**)
- Note:** Retirees cannot enroll in the HD1500 plans; Medicare eligible retirees cannot enroll in any HDHP plan or in Aetna2030; retirees who are eligible for Medicare and enroll in **Aetna HMO** are covered under the **Aetna Medicare Plan (HMO)**.

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.

Plan descriptions are available to help you compare health plan services. The plan descriptions begin on page 19 of this booklet.

Additional plan information is also available by calling the plans in which you are interested. Telephone numbers, mailing addresses, and Internet addresses are found in each plan description beginning on page 19.

* Local Employers may limit the number of plans available to their employees.

** State employees cannot participate in NJ DIRECT10. Eligible State and Intermittent employees and New Jersey National Guard enrollees, are restricted to enrollment in NJ DIRECT15 and/or the Employee Prescription Drug Plan.

CHOICE OF PROVIDER

Under the **NJ DIRECT** plans, members may see any physician, nationwide, and do not need to select a Primary Care Physician (PCP) for in-network care. NJ DIRECT plans have **in-network** benefits which apply when you select and use participating providers. NJ DIRECT plans also offer **out-of-network** benefits that allow you to use any licensed medical provider or hospital facility. In-network benefits are provided subject to the payment of the applicable copayments. Out-of-network benefits are payable subject to a deductible and coinsurance.

The **Aetna** and **Cigna** plans have participating providers from which you must select a Primary Care Physician (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.

Retired Group members enrolled in the **Aetna Medicare Plan (HMO)** must use providers who are in the Aetna Medicare Plan (HMO) network, however, the selection of a Primary Care Physician (PCP) is not required. Please contact your provider directly to verify that he or she is in the Aetna Medicare Plan (HMO) network.

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 Web site for a listing of the participating physicians. Plan telephone numbers and Internet addresses are found in each plan description beginning on page 20.

When choosing a provider under an HMO plan, be sure to obtain the physician's HMO Physician Identification Number. This identification number is required when you enroll.

PLAN PREMIUMS, COPAYMENTS, AND OTHER COSTS

Minimum Contribution for Health Coverage

Under Chapter 78, P.L. 2011, new contributions for health benefits were effective immediately (June 28, 2011) for employees whose current contract had expired and employees not covered by a union contract; however, the legislation anticipated that some administrative delay would be unavoidable while payroll systems were modified to accommodate the new contribution requirements. Chapter 78 legislation provided that once the new contributions were implemented, employers could not recover any uncollected contributions retroactive to the date of enactment.

Most employers are already collecting 1.5% of an employee's salary as a minimum contribution to the cost of health coverage, and this will continue to be the minimum required contribution under the new contribution requirements until the percentage of contribution requirement exceeds the 1.5% of salary amount.

For **State employees** paid via the State Centralized Payroll Unit and most employees of State colleges and universities, the new contributions took effect October 1, 2011 for employees whose current contract had expired and employees not covered by a union contract. Year 2 contributions will take effect on July 1, 2012 for these employees. 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% of salary. The calculation of the minimum 1.5% of salary is based on the employ-

ee's base contractual salary. In most instances, that means the salary on which pension contributions are based. However, for employees hired after July of 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. As an employee receives salary increases during the year, the amount of contribution will be adjusted upwards accordingly.

Local government and local education employees are subject to the same contributions described above and were effective immediately for employees whose contracts were expired and employees not covered by a union contract and commencing upon contract expiration for employees covered by a collective negotiations agreement. The date of implementation is as soon as administratively feasible as determined by each employer. Employees currently under a collective negotiations agreement will not be impacted by the changes described above until the agreement expires. Upon expiration, employees covered by that agreement, will begin at Year 1 of the phase-in until they reach Year 4 of the phase-in.

In the case of all employers, new employees hired on or after June 28, 2011, or after the expiration of a collective negotiations agreement that was in force on June 28, 2011, as applicable, shall contribute at the highest level (Year 4).

Note: The following charts reflect the phase-in of contribution levels for employees employed on the contribution's effective date who will pay ¼, ½, ¾ and the full amount of the contribution rate during the phase-in years.

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 the Division's Web site.

**Health Benefits Contribution for SINGLE Coverage
(Percentage of Premium)***

Salary Range	Year 1	Year 2**	Year 3	Year 4
less than 20,000	1.13%	2.25%	3.38%	4.50%
20,000-24,999.99	1.38%	2.75%	4.13%	5.50%
25,000-29,999.99	1.88%	3.75%	5.63%	7.50%
30,000-34,999.99	2.50%	5.00%	7.50%	10.00%
35,000-39,999.99	2.75%	5.50%	8.25%	11.00%
40,000-44,999.99	3.00%	6.00%	9.00%	12.00%
45,000-49,999.99	3.50%	7.00%	10.50%	14.00%
50,000-54,999.99	5.00%	10.00%	15.00%	20.00%
55,000-59,999.99	5.75%	11.50%	17.25%	23.00%
60,000-64,999.99	6.75%	13.50%	20.25%	27.00%
65,000-69,999.99	7.25%	14.50%	21.75%	29.00%
70,000-74,999.99	8.00%	16.00%	24.00%	32.00%
75,000-79,999.99	8.25%	16.50%	24.75%	33.00%
80,000-94,999.99	8.50%	17.00%	25.50%	34.00%
95,000 and over	8.75%	17.50%	26.25%	35.00%

*Member contribution is a minimum of 1.5% of base salary towards health benefits.
 **Year 2 contributions take effect on July 1, 2012 for all State employees except those whose collective negotiations agreements were in force after June 30, 2011.

**Health Benefits Contribution for FAMILY Coverage
(Percentage of Premium)***

Salary Range	Year 1	Year 2**	Year 3	Year 4
less than 25,000	0.75%	1.50%	2.25%	3.00%
25,000-29,999.99	1.00%	2.00%	3.00%	4.00%
30,000-34,999.99	1.25%	2.50%	3.75%	5.00%
35,000-39,999.99	1.50%	3.00%	4.50%	6.00%
40,000-44,999.99	1.75%	3.50%	5.25%	7.00%
45,000-49,999.99	2.25%	4.50%	6.75%	9.00%
50,000-54,999.99	3.00%	6.00%	9.00%	12.00%
55,000-59,999.99	3.50%	7.00%	10.50%	14.00%
60,000-64,999.99	4.25%	8.50%	12.75%	17.00%
65,000-69,999.99	4.75%	9.50%	14.25%	19.00%
70,000-74,999.99	5.50%	11.00%	16.50%	22.00%
75,000-79,999.99	5.75%	11.50%	17.25%	23.00%
80,000-84,999.99	6.00%	12.00%	18.00%	24.00%
85,000-89,999.99	6.50%	13.00%	19.50%	26.00%
90,000-94,999.99	7.00%	14.00%	21.00%	28.00%
95,000-99,999.99	7.25%	14.50%	21.75%	29.00%
100,000-109,999.99	8.00%	16.00%	24.00%	32.00%
110,000 and over	8.75%	17.50%	26.25%	35.00%

**Health Benefits Contribution for
MEMBER/SPOUSE/PARTNER or PARENT/CHILD Coverage
(Percentage of Premium)***

Salary Range	Year 1	Year 2**	Year 3	Year 4
less than 25,000	0.88%	1.75%	2.63%	3.50%
25,000-29,999.99	1.13%	2.25%	3.38%	4.50%
30,000-34,999.99	1.50%	3.00%	4.50%	6.00%
35,000-39,999.99	1.75%	3.50%	5.25%	7.00%
40,000-44,999.99	2.00%	4.00%	6.00%	8.00%
45,000-49,999.99	2.50%	5.00%	7.50%	10.00%
50,000-54,999.99	3.75%	7.50%	11.25%	15.00%
55,000-59,999.99	4.25%	8.50%	12.75%	17.00%
60,000-64,999.99	5.25%	10.50%	15.75%	21.00%
65,000-69,999.99	5.75%	11.50%	17.25%	23.00%
70,000-74,999.99	6.50%	13.00%	19.50%	26.00%
75,000-79,999.99	6.75%	13.50%	20.25%	27.00%
80,000-84,999.99	7.00%	14.00%	21.00%	28.00%
85,000-99,999.99	7.50%	15.00%	22.50%	30.00%
100,000 and over	8.75%	17.50%	26.25%	35.00%

*Member contribution is a minimum of 1.5% of base salary towards health benefits.
 **Year 2 contributions take effect on July 1, 2012 for all State employees except those whose collective negotiations agreements were in force after June 30, 2011.

Retiree Contributions

There were no changes to contributions for *current retirees* under Chapter 78, P.L. 2011. 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 current 1.5% of salary/retirement allowance contribution requirement, but must still attain 25 years of service credit prior to retirement to qualify for State or employer 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 and 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 collective negotiations agreement that was in force on June 28, 2011, will contribute in retirement in accordance with the terms of the collective negotiations agreement 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 and 15 years of service with the employer, as applicable, prior to retirement to qualify for State or employer contributions toward post-retirement medical coverage.

Employees who are not grandfathered (as outlined above) 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 charts above and determined by the annual retirement allowance, including any cost-of-living adjustments. A *minimum* contribution of 1.5% of the monthly retirement allowance is required.

Copayments and Other Costs

In-Network

NJ DIRECT in-network benefits, **Aetna HMO**, and **Cigna HealthCare HMO** require copayments for routine services such as office visits, use of emergency rooms, etc.

- **NJ DIRECT10** copayments for in-network visits to a primary doctor or a network specialist are \$10.
- **NJ DIRECT15** copayments for in-network visits to a primary doctor or a network specialist are \$15.
- **NJ DIRECT1525** copayments for in-network visits to a primary doctor are \$15 and visits to a network specialist are \$25.
- **NJ DIRECT2030** copayments for in-network visits to a primary doctor are \$20 and visits to a network specialist are \$20 for children and \$30 for adults.
- For most State employees, **Aetna HMO** and **Cigna HealthCare HMO** copayments for visits to a primary doctor and visits to a referred specialist are \$15.

- For most local government employees, local education employees, and all retirees, **Aetna HMO/Aetna Medicare Plan (HMO)** and **Cigna HealthCare HMO** copayments for visits to a primary doctor and visits to a referred specialist are \$10.
- **Aetna1525** and **Cigna1525** copayments for visits to a primary doctor are \$15 and visits to a referred specialist are \$25.
- **Aetna2030** and **Cigna2030** copayments for visits to a primary doctor are \$20 and visits to a referred specialist are \$20 for children and \$30 for adults.

Out-of-Network

NJ DIRECT out-of-network benefits require that an annual deductible be met. Deductibles are listed in the *NJ DIRECT Member Handbook* and the *Plan Comparison* charts produced by the Division of Pensions and Benefits. The handbook and comparison information is available over the Internet at: www.state.nj.us/treasury/pensions/health-benefits.shtml

After deductibles are met, covered services are reimbursed subject to coinsurance based on the “reasonable and customary” allowance for the service.

- Most **NJ DIRECT10** out-of-network services are reimbursed at 80% of the “reasonable and customary” allowance after annual deductibles are met.
- Most **NJ DIRECT15**, **NJ DIRECT1525** and **NJ DIRECT2030** out-of-network services are reimbursed at 70% of the “reasonable and customary” allowance after annual deductibles are met.

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

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

High Deductible Health Plans (HDHP)

- **NJ DIRECT HD4000**, **Aetna HD4000**, and **Cigna HD4000** require that an annual **in-network** deductible* (\$4,000 individual/\$8,000 family) be met followed by an **in-network** out-of-pocket maximum (\$1,000 individual/\$2,000 family).
- **NJ DIRECT HD1500**, **Aetna HD1500** and **Cigna HD1500** require that an annual **in-network** deductible* (\$1,500 individual/\$3,000 family) be met followed by an **in-network** out-of-pocket maximum (\$1,000 individual/\$2,000 family).
- Most **NJ DIRECT HD4000** and **NJ DIRECT HD1500 out-of-network** services are reimbursed at 60% of the “reasonable and customary” allowance after annual deductibles are met.

*The entire deductible must be met before any benefits are paid.

Member Handbooks

For additional information about deductibles, coinsurance, and other out-of-pocket costs, see the medical plan member handbooks for each of the SHBP/SEHBP plans — Horizon NJ DIRECT, Aetna HMO, Cigna HealthCare HMO, the Prescription Drug Plans, the Employee Dental Plans, and the Retiree Dental Expense Plan.

The member handbooks are plan documents that describe the terms and conditions of coverage and the benefits available under those plans. The handbooks are available over the Internet at:

www.state.nj.us/treasury/pensions/health-benefits.shtml

MEDICAL PLAN DESCRIPTIONS

The information on the following plan description pages is supplied by each individual medical plan and intended to provide a brief overview of the plan and the benefits offered. Every effort has been made to ensure the accuracy of the information; however, State law and the New Jersey Administrative Code govern the SHBP and 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, 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.**

Certain benefits or prescription drugs may require precertification prior to receiving services or purchase. Please contact your health plan for details.

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



Horizon Blue Cross Blue Shield of New Jersey

NJ DIRECT plans, administered by Horizon Blue Cross Blue Shield of New Jersey, provide members with all the features and services described below, as well as access to the nation’s largest participating physician network. With a choice of plan options, we are *Making Healthcare Work* for you.

NJ DIRECT10	NJ DIRECT1525	NJ DIRECT HD4000
NJ DIRECT15	NJ DIRECT2030	NJ DIRECT HD1500

Direct Network Access, No Referrals — NJ DIRECT members are *not* required to choose a Primary Care Physician (PCP). Members can visit physicians and health care professionals in the Horizon Managed Care Network in New Jersey and the BlueCard® PPO network outside New Jersey *without a referral*.

Receive Care Nationwide, Worldwide — NJ DIRECT provides in-network coverage for members who live or travel outside of New Jersey, throughout the United States and around the world, using the BlueCard® PPO network.

Flexibility — NJ DIRECT provides a choice in receiving medical care — in-network or out-of-network. Members obtain the highest level of benefits and save on out-of-pocket expenses by receiving care from participating physicians, health care professionals, and facilities in the Horizon Managed Care Network in New Jersey and the BlueCard® PPO network outside of New Jersey. Out-of-network benefits allow members to obtain care to treat illness or injury from eligible physicians, hospitals, and health care professionals who do not participate with NJ DIRECT. Members may use out-of-network benefits to maximize choice, but may have to pay more for the care received.

Preventive Care — NJ DIRECT provides in-network coverage for most preventive care services, such as annual physical and gynecological exams, well baby/child medical care, immunizations, and annual vision exams, when services are provided by a participating physician.

Behavioral Health & Substance Abuse Care — NJ DIRECT has an extensive national network of participating health care professionals providing a full range of counseling services.

Prescription Drug Coverage — All NJ DIRECT members are offered prescription drug coverage. The copayment plans have coverage through the Employee Prescription Drug Plan or the State Prescription Drug Reimbursement Program (both administered by Medco) or a private prescription drug plan. Members enrolled in high-deductible plans are not eligible for these drug plans. Instead, prescription drug coverage for NJ DIRECT HD1500 and NJ DIRECT HD4000 is integrated with the medical plan and is subject to a deductible and coinsurance.

For details regarding all the NJ DIRECT benefit plans, please refer to the NJ DIRECT Member Handbook. Certain services require recertification, including hospitalization, surgery, diagnostic procedures, and behavioral health/substance abuse services.

NJ DIRECT HEALTH & WELLNESS PROGRAMS AND RESOURCES

NJ DIRECT members have access to programs and resources designed to support healthy living, including:

- | | | |
|------------------------|----------------------------|----------------------------------|
| 24/7 Nurse Line | My Health Manager | Chronic Care Program |
| Case Management | PRECIOUS ADDITIONS® | Wellness Discount Program |

Details on these programs are listed on the next page and on www.HorizonBlue.com/shbp

24/7 Nurse Line — A unique health information service available to NJ DIRECT members 24 hours a day, seven days a week, at 1-866-901-7477, provides a toll-free health information line and online live nurse chat staffed by registered nurses, along with consumer-friendly educational materials, all designed to assist members in making informed health care decisions.

My Health Manager — Powered by WebMD®, this is a personalized online interactive health resource available to NJ DIRECT members. Key features of *My Health Manager* include:

- *Health Assessment Tool*
- *Hospital Quality Comparison Tool*
- *Personalized Health Comparison Tool*
- *Medication Center*
- *Condition Centers*
- *Treatment Cost Estimator*
- *Symptom Checker*
- *Personal Health Record*

Chronic Care Programs — For NJ DIRECT members with ongoing health problems, including:

- *Asthma*
- *Chronic Obstructive Pulmonary Disease*
- *Chronic Kidney Disease*
- *Diabetes*
- *Heart Failure*
- *Multiple Sclerosis*
- *Coronary Artery Disease*
- *Hepatitis C*
- *Weight Management*

These programs help members better manage their health and provide support for managing the day-to-day challenges of living with a chronic condition.

Case Management and Member Advocacy Program — Services are provided confidentially to NJ DIRECT members and families facing complex medical situations. The focus is on helping individuals manage complex health care situations by simplifying navigation, coordinating care, and providing better understanding of policies and procedures.

PRECIOUS ADDITIONS® — Prenatal education program helps NJ DIRECT members who select an in-network Ob/Gyn for prenatal care. In addition to information about pregnancy and prenatal care, participants receive a prenatal care class discount and reminders about proper postpartum care and childhood immunizations.

Horizon Wellness Discount Programs — Enables NJ DIRECT members to save money on products and services beyond their health care coverage. Horizon BCBSNJ has relationships with a variety of businesses and can provide discounts and savings on popular products and services, such as:

- *Gym Memberships*
- *Hearing Aids*
- *Laser Vision Correction*
- *Medic Alert*
- *Vitamins*
- *Weight Loss*
- *Massage Therapy*
- *Homeopathic Remedies*
- *Eyeglasses and Contact Lenses*
- *Yoga*
- *Cord Blood Banking*

MinuteClinic® — Walk-in health care centers at select CVS Pharmacy locations throughout New Jersey offer board-certified nurse practitioners, supervised by licensed New Jersey physicians, who can diagnose, treat, and prescribe medication for common ailments when the member's physician's office is not open. MinuteClinic® locations are listed on www.MinuteClinic.com or www.HorizonBlue.com/shbp

QUESTIONS?

Contact a NJ DIRECT Member Services Representative toll-free at 1-800-414-SHBP (7427) from 8 a.m. to 6 p.m. (EST), Monday through Friday

Member Online Services at www.HorizonBlue.com/shbp

accessible Monday through Friday, 8 a.m. to 10 p.m., (EST) and Saturday, 8 a.m. to 4 p.m. (EST) provides access to user-friendly, self-service tools enabling members to: verify enrollment, update coverage information, print claim payment statements or proof of coverage letters, obtain benefit information, request duplicate ID cards, view claim status, visit *My Health Manager*, and access the online *Provider Directory*.

NJ DIRECT is administered by Horizon Blue Cross Blue Shield of New Jersey, an independent licensee of the Blue Cross and Blue Shield Association.

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Three Penn Plaza East, Newark, New Jersey 07105



Enjoy all the benefits of being an Aetna member such as: routine checkups; hospitalization and surgery; specialty care; diagnostic testing; vision services; emergency care; anytime, anywhere, national networks and discount programs.

Network Access – When it comes to health care, nothing may be more important to our members than having access to quality doctors and hospitals. Members have access to a national network of participating providers. So we're with you wherever you go.

Electronic Referrals – Your PCP may refer you to a network specialist as part of your treatment plan. Depending upon the Aetna plan you select you may be required to obtain PCP referrals for specialty care. Electronic referrals are available in most PCP offices. When available, the PCP's office can electronically transmit your referral to participating specialists. This eliminates the need to pick up a written referral once your PCP has authorized specialty care. Check with your PCP to inquire if they have the ability to use electronic referrals.

Health Plan Options that make it easier to manage your health and health care costs.

Aetna HMOs – Choose the HMO plan that's right for you. Members must use providers who are in the Aetna HMO network and the selection of a PCP is required.

Aetna Medicare Plans (HMO) – Medicare Advantage HMO plans for retired members enrolled in Medicare. Aetna's Medicare Plans (HMO) are primary to Medicare and pays eligible expenses directly, replacing the need for claims to first be paid by Medicare and then by a secondary plan. Members must use providers who are in the Aetna Medicare Plan (HMO) network, however, the selection of a PCP is not required. Please contact your provider directly to verify that he or she is in the Aetna Medicare Plan (HMO) network.

Aetna High Deductible Health Plans – Choice of health plan for coverage and a HSA fund to help pay for it. You must use providers who are in the Aetna network, however, the selection of a PCP is not required. Referrals for specialty care are not required.

Open Access Programs – Members have **direct access** (no referral needed) to participating

obstetricians/gynecologists (OB/GYN). Members are covered for routine well woman exams, including a Pap smear, gynecological-related problems, follow-up care, and obstetrical care. Members also have direct access to participating providers for routine mammography's and routine vision care. Please refer to your Aetna Member Handbook for frequency limitations.

Emergency Care – If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. Members who are traveling outside their service area or students who are away at school are covered for emergency and urgently needed care.

Aetna Navigator™ – A powerful Web-based tool designed to help you access and navigate a wide range of health information and programs. Navigator provides a single source for online benefits and health-related information. As an enrolled Aetna member you can register for a secure, personalized view of your Aetna benefits 24 hours a day, 7 days a week where you have Internet access. Navigator allows you to request member ID cards, verify eligibility, review plan coverage details, review claim status, claim detail information and more. To register, go to www.aetna.com/statenj

DocFind® – It's easy to choose a PCP, search for participating physicians, hospitals and other health care providers from our extensive network via the Internet. You can select a provider based on geographic location, medical specialty, hospital affiliation, and/or languages spoken. In addition, you can obtain maps, driving directions, and physician performance summaries. DocFind is updated virtually every day, giving you access to the most up-to-date list of participating providers. To use DocFind, simply go to www.aetna.com/docfind/custom/statenj Member Services is also available to assist you by calling the number on the back of your ID card.

Personal Health Record – This secure, private, online resource makes it easy for you to view, access, and manage your health information.

When you access your Personal Health Record, you will see that much of your medical history is already included. That makes it easy to enter more information to create a comprehensive picture of your overall health. Use it to track your health events, print it to help you fill out medical forms, or share the information with your doctor. Once you are an Aetna member, access your Personal Health Record through Aetna Navigator™ at www.aetna.com/statenj click on Member Resources, Navigator, and then Personal Health Record.

Aetna Health Connections – A comprehensive Disease Management program designed to help you optimize your health when any one of 34 plus conditions has been identified. If you live with a chronic condition such as asthma, diabetes, heart failure, coronary artery disease, GERD, or migraines, Aetna Health Connections gives you the tools to prevent or delay complications, increase confidence in managing your condition and improve the overall quality of your life.

Have health related questions and need answers? – The *Informed Health Line* provides members with a toll free line to registered nurses experienced in providing information on a variety of health topics. This service is available 24 hours a day, 7 days a week. To contact the *Informed Health Line* call toll free 1-800-556-1555.

Women's Health Care – Aetna is committed to providing a variety of services and education on issues and concerns shared by women through all stages of their life. We include programs in our plans that support women's unique health care needs. See our Web site for more information www.aetna.com/statenj.

Aetna VisionSM Discount Program – You are eligible to receive discounts on eyeglasses, contact lenses, and additional vision related items through the Aetna VisionSM Discount Program at

more than 13,000 locations nationwide. The program also includes a discount on Lasik surgery. For more details about the Aetna VisionSM Discount Program from EyeMed Vision Care and to receive a listing of Vision One stores in your area, call 1-800-793-8616 Monday through Saturday 8:00 a.m. – 11:00 p.m., Sundays 11:00 a.m. – 8:00 p.m. Eastern Time.

Alternative Health Care Programs – This program offers access to alternative therapies and products for our members. Call Member Services for information.

◆ **Natural Alternative** services available at reduced rates.

- Acupuncture therapy
- Chiropractic manipulation (after basic benefit)
- Massage therapy
- Nutritional counseling

◆ **Vitamin Advantage** – you can save on the purchase of over-the-counter vitamins and nutritional supplements.

◆ **Natural Products** – this program provides savings on many health-related products.

Other Discount Programs – Aetna members are eligible for discounts on:

- ◆ **Weight Loss Programs** like Jenny Craig®.
- ◆ **Fitness Clubs** – nearly 10,000 clubs to choose from nationwide including Bally Total Fitness, Curves, Gold's Gym, Powerhouse, and many more!
- ◆ **Exercise Equipment** like elliptical machines and exercise videos.
- ◆ **Sonicare®** electric toothbrush, EPIC gum, mints, toothpastes, and other oral health care products.
- ◆ **SpaWish** gift certificates.
- ◆ **Zagat** healthy dining.

Employees and Non-Medicare Eligible Retirees can contact
Member Services at 1-877-StateNJ (1-877-782-8365)

Medicare Eligible Retirees can contact
Aetna Medicare Plan (HMO) at 1-866-234-3129

Customer Service Representatives are available to answer your questions
Monday through Friday from 8:00 a.m. – 6:00 p.m. Eastern Time

Your complete guide to Aetna benefits is available at our customized
SHBP/SEHBP Web site at www.aetna.com/statenj.

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company. Employer-funded plans are administered by Aetna Life Insurance Company or Aetna Health Administrators.



A Business of Caring.

The National Committee for Quality Assurance has awarded Cigna HealthCare of New Jersey and Cigna HealthCare of New York a three-year Full Accreditation.

Welcome

Choosing health benefits is an important – and very personal decision. We want to help you make an informed decision.

Our plans cover medical care when you're sick, but also include coverage for preventive care services that keep you well, coverage when you're away from home, and wellness programs to help you enhance your health.

With Cigna HealthCare, service, health education, and information are at your fingertips. We invite you to take a look at "It's Time to Feel better" www.itstimetofeelbetter.com.

Quality health care from in-network providers

Our HMO plan gives you access to quality care from our broad network of participating physicians. At enrollment, you choose a primary care physician (PCP) for yourself and each of your covered dependents. Your PCP will provide routine care, refer you to in-network specialists, and file claim forms. You can change your PCP at any time.

Our HMO plans feature:

- Paperless Referrals
- OB/GYN Direct Access

Health and wellness programs

As a Cigna member, you have access to valuable information and support:

24-hour access to health information — call the Cigna HealthCare 24-Hour Health Information LineSM at 1-800-CIGNA24, and get the answers to your health questions, 24 hours a day, nationwide. Speak with a registered nurse any hour of the day or night for:

- Detailed answers to your health questions.
- Helpful home care suggestions.
- Help in choosing the most appropriate care.

- Help in locating nearby providers

You can also learn about hundreds of health topics through our library of audio tapes.

Member discounts — through Healthy Rewards[®], you get access to a full range of health and wellness service often not covered by many traditional benefit plans. Programs include:

- Weight Watchers[®]
- QuitNet and Tobacco Solutions smoking cessation programs
- Chiropractic Care
- Massage Therapy
- Eye exams, frames, and lenses
- Fitness club memberships
- Magazine subscriptions
- And much more!

(Discount programs are subject to change)

Quality transplant care — access care from nationally recognized facilities in the Cigna LIFE-SOURCE Transplant NetworkSM.

Cigna Personal Health Team

Free live and online support to improve your health! You decide what services will work for you when you want them, or Cigna may contact you. Call 1-800-CIGNA24 for live support from your health advocate or log on to myCigna.com for self-service resources.

Get the support you need to improve your lifestyle — If tobacco or stress are affecting your health ability to live a balanced life, it may be time to take the first step toward making some changes. Use our online or telephone coaching programs – or both – for the support you need to improve your lifestyle.

Support for chronic conditions – manage your chronic condition with help from the Cigna Personal Health Team.

The Personal Health Team can help you:

- Manage a chronic health condition.
- Create a personal care plan.
- Understand medications or your doctor's orders.
- Identify triggers that affect your condition.
- Make educated decisions about your treatment options.
- Know what to expect if you need to spend time in the hospital.
- Improve your lifestyle by coping with stress, becoming tobacco-free, maintaining good eating habits, and managing or losing weight.

The personal health team supports those with the following conditions: Asthma, Heart Disease, COPD, Diabetes, Peripheral Arterial Disease, Low Back Pain, Osteoarthritis, Depression and Anxiety.

Healthy moms and babies — give your baby-to-be a healthy start with our Healthy Babies® program. When you enroll, you'll get:

- Free educational materials about pregnancy and babies, including information from the March of Dimes®.
- Round-the-clock access to a toll-free information line staffed by experienced registered nurses.
- You may also be eligible for support from a registered nurse if you or your baby has special health care needs.

myCigna.com

Your personalized health and wellness manager, information center, and benefits resource – all just a click away.

Personal health and wellness manager — combining your plan information with WebMD tools, *myCigna.com* helps you identify health risks, learn about conditions, treatments and medications, and take steps to stay healthy.

My Health Assessment and online health coaching programs — the health assessment provides you with a snapshot of the current state of your health. Based on your responses, you will

learn if you are at risk for certain conditions like diabetes or high blood pressure. Further, you will receive a Web invitation to join one of our online Health Coaching Programs for the support you need to get healthy and stay healthy.

Information center — chart your progress on key health indicators, store your information where you can find it quickly and easily, and explore a range of health and wellness topics.

Benefits resource — find out more about Cigna HealthCare plans and programs to better understand how your plan works and help you get the most from your benefits.

Emergency Care

No matter where you travel in the U.S. or worldwide, you are covered for emergency care.

- You can go to any emergency facility or hospital, anywhere, even one that is not in the Cigna HealthCare network.
- You do not need a referral or any authorization before receiving emergency care.
- You should call your primary care physician (PCP) or personal physician (or have someone call for you) for further assistance and directions on follow-up care. When possible, you should call within 48 hours.

Vision Care

To obtain vision care services in New Jersey, call Vision Service Plan toll-free at 1-800-877-7195. If you reside in another state, you may obtain a list of vision care providers on www.cigna.com

- **Exam:** Once every 12 months with appropriate copayment.
- **Hardware:** not covered

Through Healthy Rewards®, you may receive discounts on frames and lenses when you use a Healthy Rewards participating provider.

Contact Us — 24/7

1-800-CIGNA24 and a Cigna representative will assist you. Or visit:

www.myCigna.com/stateofnj

PRESCRIPTION DRUG BENEFITS

The State Health Benefits Commission and School Employees' Health Benefits Commission 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, Muse, etc.). Certain drugs that require administration in a physician's office may be covered through your medical plan.

*PDST does not apply to certain State employees and their dependents.

EMPLOYEE PRESCRIPTION DRUG COVERAGE

State Employees

The amount that State employees and their eligible dependents pay for prescription drugs is determined by the medical plan the employee selects.

Note: In the past, regardless of which medical plan you were enrolled, the Employee Prescription Drug Plan copayments were the same. As a result of the SHBP/SEHBP Plan Design Committees' actions, the copayments for prescription drugs are now determined by the medical plan you select.

The State Health Benefit Plan Design Committee establishes the copayment amounts on an annual basis. In Plan Year 2012 a State employee or dependent will pay the following copayment amounts:

- If enrolled in NJ DIRECT15, Aetna HMO, or Cigna HealthCare HMO, the copayment at a retail pharmacy for up to a 30-day supply is \$3 for *generic* drugs; \$10 for brand name drugs *without generic equivalents*; and \$25 for brand name drugs *with generic equivalents*. The mail order copayment pharmacy for up to a 90-day supply is \$5 for *generic* drugs; \$15 for brand name drugs *without generic equivalents*; and \$40 for brand name drugs *with generic equivalents*.
- If enrolled in NJ DIRECT1525, Aetna1525, or Cigna1525, the copayment at a retail pharmacy for up to a 30-day supply is \$7 for *generic* drugs; \$16 for brand name drugs *without generic equivalents*; and \$35 for brand name drugs *with generic equivalents*. The mail order copayment for up to a 90-day supply is \$18 for *generic* drugs; \$40 for brand name drugs *without generic equivalents*; and \$88 for brand name drugs *with generic equivalents*.
- If enrolled in NJ DIRECT2030, Aetna2030, or Cigna2030, the copayment at a retail pharmacy for up to a 30-day supply is \$3 for *generic* drugs; \$18 for brand name drugs *without generic equivalents*; and \$46 for brand name drugs *with generic equivalents*.

The mail order copayment for up to a 90-day supply is \$5 for *generic* drugs; \$36 for brand name drugs *without generic equivalents*; and \$92 for brand name drugs *with generic equivalents*.

- If enrolled in NJ DIRECT HD1500, NJ DIRECT HD4000, Aetna HD1500, Aetna HD4000, Cigna HD1500, or Cigna HD4000, the prescription drugs are included in the plan and are subject to a deductible and coinsurance. This means that the member pays the full cost of the medications until the deductible is reached. Once the deductible is reached, the member pays the applicable coinsurance until the out-of-pocket maximum is met.

Local Government and Local Education Employees

The amount that local government/education employees and their eligible dependents pay for prescription drugs is determined by the prescription drug plan option provided by the employer **and** the medical plan the employee selects.

Local government and local education employers may elect one of the following three options to provide prescription drug benefits to their employees:

1. The **Employee Prescription Drug Plan**: The State Health Benefit and School Employees' Health Benefit Plan Design Committees establish the copayment amounts on an annual basis.

In Plan Year 2012 a local government/education employee or dependent will pay the following copayments amounts:

- If enrolled in NJ DIRECT10, NJ DIRECT15, Aetna HMO, or Cigna HealthCare HMO, the copayment at a retail pharmacy for up to a 30-day supply is \$3 for *generic* drugs; and \$10 for *brand name* drugs. The mail order copayment for up to a 90-day supply is \$5 for *generic* drugs; and \$15 for *brand name* drugs.
- If enrolled in NJ DIRECT1525, Aetna1525, or Cigna1525, the copayment at a retail pharmacy for up to a 30-day supply is \$7 for *generic* drugs; \$16 for *preferred* brand name drugs; and \$35 for *non-preferred* brand name drugs. The mail order copayment for up to a 90-day supply is \$18 for *generic* drugs; \$40 for *preferred* brand name drugs; and \$88 for *non-preferred* brand name drugs.
- If enrolled in NJ DIRECT2030, Aetna2030, or Cigna2030, the copayment at a retail pharmacy for up to a 30-day supply is \$3 for *generic* drugs; \$18 for *preferred* brand name drugs; and \$46 for *non-preferred* brand name drugs. The mail order copayment for up to a 90-day supply is \$5 for *generic* drugs; \$36 for *preferred* brand name drugs; and \$92 for *non-preferred* brand name drugs.
- If enrolled in NJ DIRECT HD1500, NJ DIRECT HD4000*, Aetna HD1500, Aetna HD4000*, Cigna HD1500, or Cigna HD4000*, the prescription drugs are included in the plan and are subject to a deductible and coinsurance. This means that the member pays the full cost of the medications until the deductible is reached. Once the deductible is reached, the member pays the applicable coinsurance until the out-of-pocket maximum is met.

*Local education employees are not eligible for any of the HD4000 plans.

2. The Employee Prescription Drug Reimbursement Plan and HMO Prescription Drug Plan:

The Employee Prescription Drug Reimbursement Plan is available to local government and local education employees enrolled in NJ DIRECT10, NJ DIRECT15, NJ DIRECT1525, and NJ DIRECT2030, when the local public employer does not provide either the Employee Prescription Drug Plan or a private prescription drug plan. Plan benefits are available at a discounted price (eligible pharmacy price) through participating **retail pharmacies**, through **mail order**, and through **specialty pharmacy services**.

- Prescription drugs are reimbursed at 90 percent of the eligible pharmacy price when obtained through a participating retail pharmacy if you are enrolled in NJ DIRECT10 or NJ DIRECT15 and 85 percent of the eligible pharmacy price when obtained through a participating retail pharmacy if you are enrolled in NJ DIRECT1525 or NJ DIRECT2030;
- Prescription drugs are reimbursed at 80 percent of the eligible pharmacy price if you are enrolled in NJ DIRECT10, 70 percent of the eligible pharmacy price if you are enrolled in NJ DIRECT15, or 60 percent of the eligible pharmacy price if you are enrolled in NJ DIRECT1525 or NJ DIRECT2030 when obtained through a non-participating retail pharmacy.
- Prescription drugs at a discounted price are available by mail order through Medco Health Solutions, Inc., or online at: www.medco.com/statenj
- Specialty pharmacy services also apply and are provided through Accredo, Medco's specialty pharmacy.
- Horizon Blue Cross Blue Shield of New Jersey administers claim processing for the Employee Prescription Drug Reimbursement Plan in coordination with Medco Health Solutions, Inc.

The HMO Prescription Drug Plan is available to local government and local education employees enrolled in for Aetna HMO, Aetna 1525, Aetna 2030, Cigna HMO, Cigna1525, or Cigna2030, when the local public employer does not provide either the Employee Prescription Drug Plan or a private prescription drug plan. Plan benefits are available through participating **retail pharmacies**, by **mail order** through Medco Health Solutions, Inc. or online at: www.medco.com/statenj, and from **specialty pharmacy services** provided through Accredo, Medco's specialty pharmacy.

The HMO Prescription Drug Plan features a three-tier copayment design for prescription drugs that are prescribed by your Primary Care Physician (PCP) or a provider to whom your PCP has referred you.

- If enrolled in Aetna HMO or Cigna HealthCare HMO, the copayment at a retail pharmacy for up to a 30-day supply is \$5 for *generic* drugs; \$10 for *preferred* brand name drugs; and \$20 for *non-preferred* brand name drugs. The mail order copayment for up to a 90-day supply, if authorized by your PCP, is \$5 for *generic* drugs; \$15 for *preferred* brand name drugs; and \$25 for *non-preferred* brand name drugs. Specialty pharmacy services also apply.

- If enrolled in Aetna1525 or Cigna1525, the copayment at a retail pharmacy for up to a 30-day supply is \$7 for *generic* drugs; \$16 for *preferred* brand name drugs; and \$35 for *non-preferred* brand name drugs. The mail order copayment for up to a 90-day supply, if authorized by your PCP, is \$18 for *generic* drugs; \$40 for *preferred* brand name drugs; and \$88 for *non-preferred* brand name drugs. Specialty pharmacy services also apply.
- If enrolled in Aetna2030 or Cigna2030, the copayment at a retail pharmacy for up to a 30-day supply is \$3 for *generic* drugs; \$18 for *preferred* brand name drugs; and \$48 for *non-preferred* brand name drugs. The mail order copayment for up to a 90-day supply, if authorized by your PCP, is \$5 for *generic* drugs; \$36 for *preferred* brand name drugs; and \$92 for *non-preferred* brand name drugs. Specialty pharmacy services also apply.

High Deductible Health Plans (HDHP): If enrolled in NJ DIRECT HD1500, NJ DIRECT HD4000*, Aetna HD1500, Aetna HD4000*, Cigna HD1500, or Cigna HD4000*, the prescription drugs are included in the plan and are subject to a deductible and coinsurance. This means that the member pays the full cost of the medications until the deductible is reached. Once the deductible is reached, the member pays the applicable coinsurance until the out-of-pocket maximum is met.

*Local education employees are not eligible for any of the HD4000 plans.

3. **A private (non-SHBP/SEHBP) prescription drug plan** that is at least equal to the Employee Prescription Drug Plan.

RETIREE PRESCRIPTION DRUG COVERAGE

Retirees enrolled in a SHBP or SEHBP medical plan have access to the **Retiree Prescription Drug Plan**. Plan benefits are available through participating **retail pharmacies**, by **mail order** through Medco Health Solutions, Inc., and from **specialty pharmacy services** provided through Accredo, Medco's specialty pharmacy.

The plan features a three-tier copayment design except for high deductible health plans. **Retail pharmacy services** require a copayment for up to a 30-day supply of prescription drugs. **Mail order** participants can receive up to a 90-day supply of prescription drugs for one mail order copayment. **Specialty pharmacy services** are only provided via mail through Accredo. If your doctor has prescribed a specialty pharmaceutical, you will not be able to fill the prescription at a retail pharmacy.

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 the Medco Medicare Prescription Plan, a Medicare Part D plan.

Important: If you decide not to be enrolled in the Medco Medicare Prescription Plan, you will lose your *prescription drug* benefits provided by the SEHBP/SHBP. However, your *medical* benefits will continue. In order to waive the Medco Medicare Prescription Plan, you must enroll in another Medicare Part D plan. To request that you not be enrolled, you must submit a *Retired Change of Status Application* waiving your prescription drug coverage.

RETIREE PRESCRIPTION DRUG COPAYMENTS

The amount that retired members and their eligible dependents pay for prescription drugs is determined by the medical plan the retiree selects.

Effective January 1, 2012, copayments for retiree prescription drug coverage are as follows:

State Retirees and Local Government Retirees

- If enrolled in NJ DIRECT10 or NJ DIRECT15, the copayment at a retail pharmacy for up to a 30-day supply is \$10 for *generic* drugs; \$22 for *preferred* brand name drugs; and \$44 for *non-preferred* brand name drugs. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$5 for *generic* drugs; \$33 for *preferred* brand name drugs; and \$55 for *non-preferred* brand name drugs. The annual out-of-pocket maximum is \$1,351 per person.
- If enrolled in Aetna HMO/Aetna Medicare Open or Cigna HealthCare HMO, the copayment at a retail pharmacy for up to a 30-day supply is \$6 for *generic* drugs; \$12 for *preferred* brand name drugs; and \$24 for *non-preferred* brand name drugs. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$5 for *generic* drugs; \$18 for *preferred* brand name drugs; and \$30 for *non-preferred* brand name drugs. The annual out-of-pocket maximum is \$1,351 per person.
- If enrolled in NJ DIRECT1525, Aetna1525, or Cigna1525, the copayment at a retail pharmacy for up to a 30-day supply is \$7 for *generic* drugs; \$16 for *preferred* brand name drugs; and \$35 for *non-preferred* brand name drugs. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$5 for *generic* drugs; \$40 for *preferred* brand name drugs; and \$88 for *non-preferred* brand name drugs. There is no out-of-pocket maximum.
- If enrolled in NJ DIRECT2030, Aetna2030*, or Cigna2030, the copayment at a retail pharmacy for up to a 30-day supply is \$3 for *generic* drugs; \$18 for *preferred* brand name drugs; and \$46 for *non-preferred* brand name drugs. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$5 for *generic* drugs; \$36 for *preferred* brand name drugs; and \$92 for *non-preferred* brand name drugs. There is no out-of-pocket maximum.

*Medicare eligible retirees cannot enroll in Aetna2030.

- If enrolled in one of the High Deductible Health Plans**, NJ DIRECT 4000, Aetna HD4000, or Cigna HD4000, the prescription drugs are included in the medical plan and are subject to a deductible and coinsurance. This means that the member pays the full cost of the medications until the deductible is reached. Once the deductible is reached, the member pays the applicable coinsurance until the out-of-pocket maximum is met.

**Medicare eligible retirees cannot enroll a High Deductible Health Plan.

Local Education Retirees

- If enrolled in NJ DIRECT10 or NJ DIRECT15, the copayment at a retail pharmacy for up to a 30-day supply is \$9 for *generic* drugs; \$20 for *preferred* brand name drugs; and \$39 for *non-preferred* brand name drugs. The mail order (or specialty pharmaceutical)

copayment for up to a 90-day supply is \$5 for *generic* drugs; \$29 for *preferred* brand name drugs; and \$49 for *non-preferred* brand name drugs. The annual out-of-pocket maximum is \$1,318 per person.

- If enrolled in Aetna HMO/Aetna Medicare Open or Cigna HealthCare HMO, the copayment at a retail pharmacy for up to a 30-day supply is \$5 for *generic* drugs; \$12 for *preferred* brand name drugs; and \$24 for *non-preferred* brand name drugs. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$5 for *generic* drugs; \$17 for *preferred* brand name drugs; and \$29 for *non-preferred* brand name drugs. The annual out-of-pocket maximum is \$1,318 per person.
- If enrolled in NJ DIRECT1525, Aetna1525, or Cigna1525, the copayment at a retail pharmacy for up to a 30-day supply is \$7 for *generic* drugs; \$16 for *preferred* brand name drugs; and \$35 for *non-preferred* brand name drugs. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$5 for *generic* drugs; \$40 for *preferred* brand name drugs; and \$88 for *non-preferred* brand name drugs. The annual out-of-pocket maximum is \$1,318 per person.
- If enrolled in NJ DIRECT2030, Aetna2030*, or Cigna2030, the copayment at a retail pharmacy for up to a 30-day supply is \$3 for *generic* drugs; \$18 for *preferred* brand name drugs; and \$46 for *non-preferred* brand name drugs. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$5 for *generic* drugs; \$36 for *preferred* brand name drugs; and \$92 for *non-preferred* brand name drugs. The annual out-of-pocket maximum is \$1,318 per person.

*Medicare eligible retirees cannot enroll in Aetna2030.

- If enrolled in one of the High Deductible Health Plans**, NJ DIRECT 4000, Aetna HD4000, or Cigna HD4000, the prescription drugs are included in the medical plan and are subject to a deductible and coinsurance. This means that the member pays the full cost of the medications until the deductible is reached. Once the deductible is reached, the member pays the applicable coinsurance until the out-of-pocket maximum is met.

**Medicare eligible retirees cannot enroll a High Deductible Health Plan.

DENTAL PLANS

Dental coverage is available through the **Employee Dental Plans** and the **Retiree Dental Expense Plan**.

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 offered enrollment is in one of two basic types of dental plan: one of several **Dental Plan Organizations (DPOs)** or the **Dental Expense Plan**.

- The **Dental Plan Organizations (DPOs)** are companies that contract with a network of providers for dental services. You must use providers who participate with

the DPO you select to receive coverage. When using a 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 Employee Dental Plans before you enroll.

- The **Dental Expense Plan** is a PPO plan that allows 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 plan is administered under a contract with the Aetna Life Insurance Company. By using Aetna'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 plan description pages in this booklet or Fact Sheet #37, *Employee Dental Plans*. Information about reimbursement levels and copayment amounts is in the *Employee Dental Plans Member Handbook*, available on the Health Benefits home page at: www.state.nj.us/treasury/pensions/health-benefits.shtml

RETIREE DENTAL EXPENSE PLAN

The **Retiree Dental Expense Plan**, administered by Aetna Dental, is available as a separate dental plan to State and local retirees eligible to enroll in a Retired Group medical plan.

The Retiree Dental Expense Plan is a PPO plan 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 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 Expense Plan are responsible for paying the full premium cost for coverage.

For more information about the Retiree Dental Expense Plan, see the dental plan description pages in this booklet, the *Retiree Dental Expense Plan Member Handbook*, or Fact Sheet #73, *Retiree Dental Expense Plan*, available on the Health Benefits home page at: www.state.nj.us/treasury/pensions/health-benefits.shtml

DENTAL PLAN DESCRIPTIONS

The information on the following plan description pages is supplied by each individual dental plan and intended to provide a brief overview of the plan and the benefits offered. Every effort has been made to ensure the accuracy of the information; however, State law and the New Jersey Administrative Code govern the Employee Dental Plans. **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, 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.**

Certain benefits may require precertification prior to receiving services or purchase. Please contact your dental plan for details.

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



Aetna's Dental Maintenance Organization (DMO) is a claims administrator of the State Health Benefits Program Dental Provider Organization (DPO).

Aetna's DMO networks are available to employees in Delaware, New Jersey, New York, and Pennsylvania. There are no claim forms to fill out and no deductibles to pay. Each covered family member must select a participating Primary Care Dentist (PCD) to coordinate all dental care.

Dental Benefits Made Simple and Affordable!

Follow these simple steps to maximize your Aetna DMO Plan!

- ◆ **Select a Primary Care Dentist (PCD) in your area** to visit on a regular basis and refer you to specialists within the Aetna DMO network when necessary.
- ◆ Obtain the appropriate preventive care per the benefits schedule at no charge to you (cleanings, bitewing and full-mouth X-rays, and more).
- ◆ Pay a fixed dollar amount for Basic (fillings and basic restorative work) and Major Services (bridges, crowns, dentures and more), with no deductibles or annual maximums!
- ◆ It is affordable – lower monthly premium compared to the Dental Expense Plan.

For a complete copayment schedule and services that this plan does and does not cover please refer to your Employee Dental Plans Member Handbook.

Dental Health Information at Your Fingertips

Visit the *Simple Steps to Better Dental Health* Web site to find articles, illustrations, interactive tools, information on dental conditions, treatments, and more. To explore *Simple Steps to Better Dental Health* go to www.aetna.com/statenj

We offer fast, accurate customer service. Our dedicated dental service centers are staffed with dental experts who are determined to solve problems the first time, leading to fast and accurate problem resolution and claim processing.

Our technology makes it easy to get service and information when and how you want it.

- ◆ E-mail with 24 hour response time.
- ◆ 24 hour phone access

Our member Web site allows you to:

- ◆ Review your claims online
- ◆ Pick a dentist
- ◆ Price a procedure
- ◆ Obtain information
- ◆ Research dental trends

Aetna Navigator™ – A powerful Web-based tool designed to help you access and navigate a wide range of oral health information and programs. Navigator provides a single source for online benefits and dental-related information. As an enrolled Aetna member you can register for a secure, personalized view of your Aetna benefits 24 hours a day, 7 days a week where you have Internet access. Navigator allows you to request member ID cards, verify eligibility, review plan coverage details, review claim status, claim detail information and more. To register, go to

www.aetna.com/statenj

DocFind® – It's easy to choose a PCD and search for participating specialty dentists from our extensive network via the Internet. You can select a dentist based on geographic location, dental specialty, hospital affiliation, and/or languages spoken. DocFind is updated virtually every day, giving you access to the most up-to-date list of participating dental providers. To use DocFind, simply go to

www.aetna.com/docfind/custom/statenj.

Member Services is also available to assist you by calling the number on the back of your ID card.

Did You Know? Your dentist can identify a lot more than tooth decay and gingivitis. Up to 90% of whole-body illnesses, including diabetes and cardiovascular disease, show their first signs in the mouth.* That's why seeing your dentist regularly is one of the best defenses against illness — for good oral health as well as overall health.

Aetna Membership Brings You Even More

Save on vision, alternative health care, and fitness too. Yes, this is a dental insurance plan. But you can get discounts on other health services, as well! Visit Aetna Navigator or call the number on your Aetna ID card for more information on great value-added services!

*Academy of General Dentistry Web site, www.agd.org "The Importance of Oral Health." September 2003. Accessed February 2006.



Atlantic Southern Dental Foundation

A New Jersey Public Employee Dental Plans DPO Since 1984

ASDF/BeneCare provides:

- More coverage than the Dental Expense Plan at a Much, Much Lower Cost.
- Hundreds of Private Practice General Dentists and Specialists from which to choose. Convenient to where you live or work across the State.
- You may see any Participating Dentist or change Dentists at any time without prior approval. Family members may use different dentists.
- Easy to use online tools for locating participating dentists, reviewing claims, and coverage information at ***www.BeneCare.com/subscriber***

ASDF/BeneCare is a unique concept in Dental Plan Organizations:

- ASDF/BeneCare is owned by its participating dentist members — your local dentists.
- ASDF/BeneCare does not compensate participating dentists in advance at fixed monthly rates per patient.
- ASDF/BeneCare reimburses dentists for the services that they actually provide.
- ASDF/BeneCare encourages the traditional, close doctor-patient relationship and produces more comprehensive and personalized oral health care for you.

ASDF/BeneCare believes that it provides the best value, the most comprehensive access to private practice dentists and the model for comprehensive oral health care of all SHBP Dental Plan Organizations.

Please consider ASDF/BeneCare when making your important open enrollment choice. We are positive that you will be as pleased with ASDF/BeneCare as over 6,000 of your colleagues have been for the past 28 years.

For additional information, contact us directly at 1-800-843-4727

www.benecare.com

Cigna Dental Care® DHMO*

Referred to as Cigna DPO for New Jersey public employees

A dental plan that makes it easier for you to take care of your oral health



CIGNA Dental

Your plan offers coverage for a wide range of services at a cost savings. Your coverage includes:

- **Preventive care** (cleanings, x-rays, and more)
- **Basic care** (fillings, basic restorative work)
- **Major services** (bridges, crowns, root canals and more)
- **Orthodontic coverage** for children and adults

How Your Plan Works - it's easy to use when you follow these simple steps...

Step 1 - Select a Network General Dentist

- You must select a dentist who participates in the DHMO network for your benefits to apply. The network general dentist you choose will manage your overall dental care.
- Covered family members can choose their own network general dentists - near home, work or school.
- You may change your dental office for any reason. The change will become effective the first of the following month.
- Finding a DHMO network dentist is easy. There are several ways:
 - Online - Register on **myCigna.com**, or visit the online Provider Directory on **www.cigna.com**.
 - By phone - Call 1-800-CIGNA24 (1-800-244-6224) to use our automated Dental Office Locator or speak to a Customer Service representative. Or our service representative can send you a customized network directory listing via e-mail.

Step 2 - After You Enroll

- You will receive an ID Card, a Patient Charge Schedule (PCS) and other plan materials.
- You can make an appointment with your network general dentist for all covered services.
- If you require specialty care (except pediatric and orthodontic), your network general dentist will refer you to a network specialist.
- Your plan has no dollar maximums and no claim forms to file.
- Coverage for most preventive services is provided at \$0 or low charge.
- At the time of service, your dentist will collect the applicable co-payment for covered expenses as described on your Patient Charge Schedule.
- Alternate benefit provisions apply.

More Reasons to Smile

- You don't need a referral for children under seven to visit a network pediatric dentist - simply select a network pediatric dentist as a primary care dentist.
- You don't need a referral to receive care from a network Orthodontist.
- Members with both Cigna medical and dental coverage may be eligible for reimbursement of copayments for certain services to treat gum disease. The Cigna Dental Oral Health Integration Program® offers enhanced dental benefits for eligible members with certain medical conditions, including diabetes, cardiovascular disease or pregnancy. Participation in Cigna disease management programs may be required. Visit **myCigna.com** to learn more about eligibility for this program, or call the number on your ID card or 1-800-CIGNA24 (1-800-244-6224).

"*DHMO" is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features.

Cigna Dental refers to the following operating subsidiaries of Cigna Corporation: Connecticut General Life Insurance Company, and Cigna Dental Health, Inc., and its operating subsidiaries and affiliates. The Cigna Dental Care plan is provided by Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of Pennsylvania, Inc. In other states, the Cigna Dental Care plan is underwritten by Connecticut General Life Insurance Company or Cigna HealthCare of Connecticut, Inc. and administered by Cigna Dental Health, Inc.

Community Dental Associates

(856) 451-8844
www.cdaplan.com

A participating Dental Plan Organization "DPO" in the New Jersey Public Employee Dental Plans.

If you live or work in or around *Cumberland County, New Jersey...*

...CDA should be your dental plan!

Community Dental Associates "CDA" has been serving Employee Dental Plans members for over twenty years.

Though all participating DPO's in the Employee Dental Plans offer identical coverage, our providers distinguish us from our peers.

Our providers include the finest dentists in Cumberland County, New Jersey. All providers operate "private practice offices" dedicated to delivering the finest care to our members.

Plan Highlights

- Deductible - None
- Benefits Maximum - Unlimited
- Examinations - Covered
- X-rays - Covered
- Cleanings - Covered
- Routine Fillings - Covered
- Fluoride Applications for Children - Covered
- Tooth Sealants for Children - Covered
- Crowns, Root Canals, Dentures - Covered (copayments apply)
- Periodontics and Orthodontics - Covered (copayments apply)

Please refer to the *Employee Dental Plans Member Handbook* for full details and benefits.



Horizon Dental Choice Plan

Horizon Blue Cross Blue Shield of New Jersey

The Horizon Dental Choice Plan from Horizon Blue Cross Blue Shield of New Jersey Dental Programs covers 100 percent of all eligible preventive and most basic dental services with no copayments, maximums, or deductible when receiving those services from a primary Horizon Dental Choice dentist. The Horizon Dental Choice Plan also covers charges for all eligible major and specialty services with affordable copayment amounts for those services.

The key to Horizon Dental Choice is that care must be coordinated through the participating dentist that you select to use as your primary care dentist. Each member can choose his or her own primary care dentist. The primary care dentist selection can be changed within the network on a monthly basis, effective on the first day of any month by giving Horizon BCBSNJ 15-days notice. There is no out-of-network benefit for Horizon Dental Choice. If you need to see a specialist for treatment outside the scope of your primary care dentist, your primary dentist will refer you to a Horizon Dental PPO specialist

Quick Dentist Search

Please refer to the Horizon BCBSNJ online *Provider Directory* at www.HorizonBlue.com/shbp to find the names, addresses, and detailed door-to-door directions of dentists in the Horizon Dental Choice network.

24/7 Customer Service

For more information on your dental plan, please call Horizon Dental Customer Service at **1-800-4DENTAL**, Monday through Friday, from 8:00 a.m. to 6:00 p.m. (EST). In addition, Horizon BCBSNJ's automated phone system is a user-friendly self-service tool available 24 hours a day, generally including weekends. You can use the automated phone system or Member Online Services at www.HorizonBlue.com/shbp to find information on:

- Claim Status
- Enrollment verification
- Benefit information
- Additional ID cards
- Finding dentists or specialists near you
- Changing your primary care dentist

Discount Programs

Horizon BCBSNJ has established relationships with a variety of businesses to provide discounts and savings on popular products and services that you and your family may use. These select businesses are listed on the Horizon BCBSNJ Web site, www.HorizonBlue.com/shbp and include discounts on everything from alternative therapies to yoga and vitamins to vision hardware. To use any of the wellness discounts, simply follow the instructions listed online

Products are provided by Horizon Blue Cross Blue Shield of New Jersey, an independent licensee of the Blue Cross and Blue Shield Association.

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Three Penn Plaza East, Newark, New Jersey 07105

International Healthcare Services, Inc. (I.H.S.)/Healthplex

IHS/Healthplex has participated with the New Jersey Public Employee Dental Plans for more than 25 years. Our DPO Plan is available in most counties through the offices of participating, private practice dentists. Employees select a primary general dentist who is responsible for the dental care of all family members. When specialty care is needed, the general dentist will refer enrollees to participating Endodontists, Periodontists, Oral Surgeons and Orthodontists.

Healthplex has been certified as a Credentials Verification Organization by the National Committee for Quality Assurance (NCQA)* and credentials its providers according to NCQA standards. *You can be sure that all participating dentists have been thoroughly screened regarding education, licensure, malpractice history and other key elements.* In addition, we perform site visits during which we review office cleanliness, sterilization methods, record keeping and staffing. With IHS/Healthplex, you can be assured that the office you select is qualified and meets or exceeds established standards of care!

In this plan, many services are covered in full without any patient copayment: exams, x-rays, cleanings, fluoride treatments, silver fillings and plastic fillings for front teeth are *provided at no cost*. Other more complex services have patient copayments that are a fraction of usual fees. Some examples are:

- Single Porcelain/Noble Metal Crown - \$200
- Root Canal on front tooth - \$100
- Periodontal Osseous Surgery - \$175 per quadrant
- Full Denture - \$250
- Extraction of Erupted Tooth - \$20
- Orthodontics - \$1,000 for children / \$1,750 for adults (24 month case)

Private fees for these procedures can be up to seven times the copayments shown above. And, this plan has no deductibles or maximum limitations on the number of services you can receive!

Premiums in the IHS/Healthplex DPO Dental Plan are roughly half the amounts charged in the Dental Expense Plan, which also has higher out-of-pocket costs. For a list of non-covered services and limitations, please review the *Employee Dental Plans Member Handbook*. If you would like to find a participating dentist, you may do so on our Web site — ***www.healthplex.com***. Select '*Find a Dentist*' and then click the link next to '*If you are a prospective member*.' Enter Group Number 'GJ2006' where requested on the '*Locate Dentists*' screen. You may then search for '*General Dentists*' in your town, county, or Zip code. Or you may call us for plan or dentist information at 1-800-468-0600.

Thank you for considering IHS/Healthplex for your dental needs!

*NCQA is an independent, non-profit organization dedicated to assessing and reporting on the quality of America's health plans.



Whether an employee or a retiree, you'll love the flexibility of the Dental Expense Plan!

Aetna Dental is the claims administrator of the Active and Retiree Dental Expense Plans. Members enrolled in these plans receive an Aetna member identification card with a PPO network identifier.

Dental Expense Plan Network Access — When it comes to oral health, nothing may be more important to our members than having access to quality dentists. Members have access to our quality preferred provider organization (PPO) networks nationwide.

The Retiree Dental Expense Plan is only available to retirees. However, both the Active and Retiree plans offer national access to dentists and quality coverage with no referrals required.

Please note that the Dental Expense Plan has different in-network and out-of network benefits. This means that, by using Aetna's network of dental PPO providers, you have the opportunity to save on your costs when compared to using out-of-network providers.

Ah, Freedom! See any licensed dentist you choose!

- ◆ No referrals required.
- ◆ No need to choose a primary care dentist.
- ◆ Affordable coverage for cleanings, X-ray, restorative work and more.

It's your choice whenever you need dental care....

Choice 1: The best way to maximize your dollar! Simple affordable coverage by visiting a participating Preferred Provider Organization (PPO) dentist from Aetna's national PPO network.

Participating dentists have agreed to offer certain services at a negotiated rate — so you generally pay less out of pocket for your care.

- ◆ Check DocFind to see if your dentist is participating or to simply see who is participating.
- ◆ Your participating Aetna PPO dentist will submit claims for you.

Choice 2: Visit any dentist of your choice for maximum flexibility under your plan. However, you may potentially pay more out of pocket for your dental services.

- ◆ For maximum flexibility see any licensed dentist. You have the freedom to visit a licensed dentist who does not participate in the Aetna PPO network.
- ◆ Only participating dentists have agreed to discounted rates for Aetna members, so your out-of-pocket expenses will be higher when you go outside the network.
- ◆ You may have to file your own claims and you may be subject to balance billing (the difference between the amount covered by your plan and the amount charged by your dentist).

For a more complete overview of the plan including covered and not covered services please refer to your *Dental Plans Member Handbook*.

Dental Health Information at Your Fingertips

Visit the *Simple Steps to Better Dental Health* Web site to find articles, illustrations, interactive tools, information on dental conditions, treatments, and more. To explore *Simple Steps to Better Dental Health* go to www.aetna.com/statenj

We offer fast, accurate customer service. Our dedicated dental service centers are staffed with dental experts who are determined to solve problems the first time, leading to fast and accurate problem resolution and claim processing.

Our technology makes it easy to get service and information when and how you want it.

- ◆ E-mail with 24 hour response time.
- ◆ 24 hour phone access

Our member Web site allows you to:

- ◆ Review your claims online
- ◆ Pick a dentist
- ◆ Price a procedure
- ◆ Obtain information
- ◆ Research dental trends

Aetna Navigator™ – A powerful Web-based tool designed to help you access and navigate a wide range of oral health information and programs. Navigator provides a single source for online benefits and dental-related information. As an enrolled Aetna member you can register for a secure, personalized view of your Aetna benefits 24 hours a day, 7 days a week where you have Internet access. Navigator allows you to request member ID cards, verify eligibility, review plan coverage details, review claim status, claim detail information and more. To register, go to www.aetna.com/statenj

DocFind® – It's easy to choose a participating PPO dentist and search for participating specialty dentists from our extensive network via the Internet. You can select a dentist based on geographic location, dental specialty, and/or languages spoken. DocFind is updated virtually every day, giving you access to the most up-to-date list of participating dental providers. To use DocFind, simply go to www.aetna.com/docfind/custom/statenj

Member Services is also available to assist you by calling the number on the back of your ID card.

Did You Know? Your dentist can identify a lot more than tooth decay and gingivitis. Up to 90% of whole-body illnesses, including diabetes, and cardiovascular disease, show their first signs in the mouth.* That's why seeing your dentist regularly is one of the best defenses against illness — for good oral health as well as overall health.

Aetna Membership Brings You Even More

Save on vision, alternative health care and fitness too. Yes, this is a dental plan. But isn't it great to get discounts on other health services, as well?

As part of our commitment to help you maintain your overall health, we also give you valuable discounts on a variety of vision, hearing, alternative health and fitness products and services. Visit Aetna Navigator or call the number on your Aetna ID card for more information on how to access the great value-added services below!

Show your Aetna ID card at participating locations to save on:

- ◆ Eye care products, including eyeglasses, contact lenses, non prescription sunglasses and accessories
- ◆ Eye exams at thousands of locations nationwide
- ◆ LASIK eye surgery
- ◆ Hearing products
- ◆ Membership in participating health clubs
- ◆ Certain home exercise equipment
- ◆ Chiropractic, acupuncture, vitamins, and more!

*Academy of General Dentistry Web site, www.agd.org "The Importance of Oral Health." September 2003. Accessed February 2006.

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 anytime 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
Active State Employees	1-866-327-9133
Rutgers University Personnel Counseling Service EAP	(732) 932-7539
New Jersey State Police EAP	1-800-FOR-NJSP
University of Medicine and Dentistry of New Jersey EAP	(973) 972-5429

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 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 and thereby increase 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)** 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 limitations on civil unions and same-sex domestic partners, on page 44).

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 one of the High Deductible Plans (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 Division of Pensions and Benefits by Fringe Benefits Management Company, a Division of Wagesworks.

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.

Fact Sheet #44, *Tax\$ave*, outlines the Tax\$ave Program and may be obtained from your benefits administrator or from the Division of Pensions and Benefits. You can also visit the Division's Tax\$ave Internet page at: www.state.nj.us/treasury/pensions/taxsave.shtml

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 **Premium Option Plan (POP)** may effect your participation in the State Health Benefits Program.

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 “Declining POP” on page 44).

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 below), 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.
- The taking of an approved unpaid leave of absence.
- A change in a spouse's or eligible dependent's employment status resulting in their 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.

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 Internal Revenue Service 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 Internal Revenue Code Section 152 — before an out-of-pocket medical expense incurred by the partner can be reimbursed under the **Unreimbursed Medical Spending Account** and before any premiums that the employee pays for the partner's coverage can be made on a pre-tax basis under the **Premium Option Plan**. 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 Unreimbursed Medical Spending Account 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 Premium Option Plan. (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

ACTIVE EMPLOYEE ENROLLMENT

You are not covered until you enroll in the SHBP or SEHBP. You must fill out a *Health Benefits Program Application* and provide all the information requested along with any required supporting documentation. 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” on page 46 for exceptions).

Supporting Documentation Required for Enrollment of Dependents

The SHBP and SEHBP are required to ensure that only eligible employees and 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 in addition to the enrollment application. See page 70 for more information about the documentation a member must provide when enrolling a new dependent for coverage.

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 first biweekly payroll period of the new plan year for State employees paid through the State’s Centralized Payroll Unit, and January 1 of the following year for all other State and local employees. Completed applications must be returned to your human resources representative or payroll officer 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 page 8); and
- delete dependents (this can also be done at any time during the year).

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.

Waiver of Coverage

An employer other than the State participating in the SHBP or SEHBP may allow an employee who is covered as a dependent under a spouse's or partner's employer provided health benefits coverage, to waive SHBP or 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 you should contact your benefits administrator or human resource representative. To change your coverage due to any of the circumstances listed below, **you must submit a completed *Health Benefits Program Application* and all required supporting documentation within 60 days of the event.** See page 70 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 application.**
- You enter into a civil union or same-sex domestic partnership and want to enroll your eligible partner and 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 accompany the application.*** (May not apply to all employees, see page 7 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 accompany the application.**
- 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 spouse's, civil union partner's, eligible same-sex domestic partner's, or eligible dependent's employment status changes resulting in a loss of health coverage. **A photocopy of your spouse/partner's and/or dependent's *Certificate of Continued Coverage* and required supporting documentation must accompany the application.**

- You are going on a leave of absence and cannot afford to pay for coverage. You can reduce your coverage, for example, from “Family” to “Parent and Child” coverage when you go on leave and increase it back to “Family” upon your return to work.

You are eligible to change your coverage to another plan under the following circumstances.

- You return from a leave of absence. If you elected not to continue benefits while on leave of absence, or you missed the open enrollment period, upon your return from leave you may elect to enroll in any plan for which you are eligible or at any coverage level as appropriate.

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 completed *Health Benefits Program Application* and all required supporting documentation. Your enrolled eligible 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 or 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.
- 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 “Transfer of Employment” on page 48.)

Coverage changes involving the addition of dependents are effective retroactive to the date of the event (marriage, civil union, birth, adoption, etc.) provided that the application and all required supporting documentation is filed within 60 days of the event.

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

- 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.
- Children covered under the provisions of Chapter 375, P.L. 2005, 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
- transfer from one participating employer to another; **and**
- file a new *Health Benefits Program Application* listing the former employer in the appropriate section of the application.

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.
- Suspension (COBRA continuation only).

While you are on 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” or “Single” coverage. Please note that it is necessary to complete a *Health Benefits Program Application* to decrease your coverage and also to reinstate it 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 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, if any. To qualify for the federal Family and Medical Leave Act of 1993 (FMLA), you must have been employed for at least 12 months, have a personal illness, have a newborn child, or need to care for an ill family member. The FMLA defines the family member as a spouse, parent, or child. The FMLA provides up to 12 weeks in a 12-month period.

To qualify for the New Jersey Family Leave Act (NJFLA), you must have a need to care for an ill family member or a newborn child. There is no provision for an employee's own personal illness. The NJFLA provides up to 12 weeks in a 24-month period.

If an employee takes a leave for the care of a family member, both the FMLA and the NJFLA will run concurrently. If an employee takes a leave for maternity, they are on the FMLA. After their doctor releases them from their maternity leave, they can take the NJFLA for the care of the newborn child. This then provides the parent with up to 24 weeks of employer paid benefits.

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, and 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, that portion or the premiums that you would normally pay, if any.

Suspension

If you are suspended from work, you are not eligible for employer-paid coverage. You may be eligible for coverage under COBRA (see page 57) 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 complete a *Health Benefits Program Application* (and include any required documentation for new dependents). You must complete this application 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 and the completion of a *Health Benefits Program Application*.

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 file a new *Health Benefits Program Application* **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 (State employees, see “Effect of POP Participation” in the “Tax\$ave” section on page 42);
- your employment terminates;
- your hours are reduced so you no longer qualify for coverage;
- you do not make required premium payments;
- you enter the Armed Forces and are eligible for government-sponsored health services;
- your plan discontinues services in your area and you do not submit an application to the Health Benefits Bureau 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 page 8) will end if:

- your coverage ceases for any of the reasons listed above;
- you die (**dependent coverage terminates the 1st day of the biweekly coverage period following the date of death of State employees paid through the State’s Centralized Payroll Unit, or the 1st 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 — see page 8);
- your payment for coverage is not made when due;
- your enrolled dependent enters the Armed Forces; or
- your dependent becomes enrolled on their own as an SHBP or SEHBP subscriber.

Medicare Parts A and B

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 at work. **However, if you or your dependents become eligible for Medicare due to End State Renal Disease (ESRD), you and/or your dependents must enroll in Medicare Parts A and B even though you are actively at work.** For more information see the “Medicare Coverage” section on page 52.

Medicare Part D

Most **employees** who do enroll in Medicare and/or an **employee’s** Medicare eligible dependents need not enroll in Medicare Part D prescription drug coverage. Some members who qualify for low income subsidy programs may find it beneficial to enroll in Medicare Part D. However, once you and/or your dependents enroll in a Medicare Part D plan, the person enrolled in Medicare Part D will lose their SHBP or SEHBP prescription drug coverage. In addition, the SHBP and SEHBP will not cover the costs of any drugs that are not covered by the Medicare Part D plan.

RETIREE ENROLLMENT

You are not covered as a retiree until you enroll in the SHBP or SEHBP. You must fill out a *Retired Coverage Enrollment Application* and provide all the information requested within 60 days of being offered enrollment.

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

Supporting Documentation Required for Enrollment of Dependents

The SHBP and SEHBP are required to ensure that only eligible employees and retirees, and their dependents, are receiving health care coverage under the program. 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 in addition to the enrollment application. See page 70 for more information about the documentation a member must provide when enrolling a new dependent for coverage.

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.

Waiver of Coverage

As an eligible retiree:

- You may waive coverage with Retired Group coverage 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 eligible 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 notify the Health Benefits Bureau of the Division of Pensions and Benefits within 60 days of the loss of coverage, submit a completed *Retired Change of Status Application*, and provide proof that the previous coverage was in effect.
- If you are otherwise eligible for enrollment under the provisions of Chapter 330, P.L. 1997, 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 notify the Health Benefits Bureau of the Division of Pensions and Benefits within 60 days of the loss of coverage and request enrollment materials.

MEDICARE COVERAGE IS REQUIRED IF ELIGIBLE

Medicare Part A and Part B

IMPORTANT: A Retired Group member and/or dependent spouse, civil union partner, eligible 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.

You will be required to submit documented evidence of enrollment in Medicare Part A and Part B when you or a covered dependent becomes eligible for that coverage. 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. Send your evidence of enrollment to the Health Benefits Bureau, Division of Pensions and Benefits, PO Box 299, Trenton, New Jersey 08625-0299 or fax it to (609) 341-3407. If you do not submit evidence of Medicare coverage under both Part A and Part B, you and/or your dependents will be terminated from coverage. Upon submission of proof of full Medicare coverage, your coverage will be reinstated by the Health Benefits Bureau on a prospective basis.

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

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 Medco Medicare Prescription Plan.

Important: If you decide not to be enrolled in the Medco Medicare Prescription Plan, you will lose your prescription drug benefits provided by the SEHBP/SHBP. However, your medical benefits will continue. In order to waive the Medco Medicare Prescription plan, you must enroll in another Medicare Part D Plan. To request that you not be enrolled, you must submit a *Retired Change of Status Application* waiving your prescription drug coverage.

Medicare Eligibility

A member may be eligible for Medicare for the following reasons:

- ***Medicare Eligibility by Reason of Age***

A member (the retiree or covered spouse/partner) is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if he or she is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his/her 65th birthday.

The Retired Group health plan is the secondary plan (the Aetna Medicare Open Plan pays primary to Medicare).

- ***Medicare Eligibility by Reason of Disability***

A member (the retiree or covered spouse/partner or dependent) who is under age 65 is considered to be eligible for Medicare by reason of disability if they have been receiving Social Security Disability benefits for 24 months.

The Retired Group health plan is the secondary plan (*the Aetna Medicare Open Plan pays primary to Medicare*).

- **Medicare Eligibility by Reasons of End Stage Renal Disease** (*see "Note" below*)

A member usually becomes eligible for Medicare at age 65 or upon receiving Social Security Disability benefits for two years. A member (the retiree or covered spouse/partner or dependent) who is 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 their own or through a family member (including a spouse).
- 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.

As of January 1, 2000, 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" below*)

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 Parts A and B benefits. During the initial three-month period, **the group health plan is primary**.

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

During the "coordination of benefits" period, **Medicare is secondary to the group health plan coverage**. Claims are processed first under the health plan. 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" below*)

After the coordination of benefits period ends, **Medicare is considered the primary payer and the group health plan is secondary**.

Note: If you are an Aetna 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 Aetna Medicare Open 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

(Does not apply to Aetna Medicare Open Plan)

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.

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.

ADDITIONAL RETIREE ENROLLMENT INFORMATION

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, eligible 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. A *Retired Change of Status Application* 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 page 70 for more information about the documentation a member must provide when enrolling a new dependent for coverage.

If the application to add a spouse, civil union partner, eligible same-sex domestic partner, or dependent is not received within 60 days of the status change (or required documentation is not provided), there will be a minimum 2 month waiting period from the date the enrollment application is received 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 Division of Pensions and Benefits of any change in family status.** If family members are not properly enrolled, claims will not be paid.

Change of Coverage

To change Retired Group coverage you must complete a *Retired Change of Status Application* which is available on our Web site: www.state.nj.us/treasury/pensions/health-benefits.shtml or by contacting the Office of Client Services at the Division of Pensions and Benefits (see page 76).

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 enter into a civil union or same-sex domestic partnership and want to enroll your eligible partner. Photocopies of the *Civil Union Certificate*, or *Certificate of Domestic Partnership* and additional supporting documentation are required for enrollment. (May not apply to all retirees, see page 7 for additional information about 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; child or turns age 26).
- Your spouse/partner's employment status changes resulting in a significant change in health coverage.

IMPORTANT: Retirees should immediately notify the Health Benefits Bureau of changes in family status. (1) Deleting coverage for dependents may affect premium rates and, although claims for ineligible dependents cannot legally be paid, *premiums cannot be reduced until appropriate notification is provided to the Health Benefits Bureau.* (2) Failure to submit a *Retired Change of Status Application* to remove from your coverage a deceased or ineligible spouse/partner for whom you receive a Medicare Part B reimbursement will result in the need for you to reimburse all incorrectly paid amounts.

Effective Dates

You are responsible for notifying the Health Benefits Bureau of 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.

The effective date of **any other change or termination of coverage** is based on the billing cycle in which the change or termination is received. In most cases, if an application for a change is received before, for example, January 15, the effective date will be February 1. If the application is received after January 15, the effective date will be March 1. The effective date of any transaction may be delayed if the member fails to submit the appropriate application and supporting information on a timely basis.

End of Coverage

Your coverage under the Retired Group terminates if:

- you formally request termination in writing, or by completing a *Retired Change of Status Application*;
- your retirement is canceled;
- your pension allowance is suspended;
- you do not pay your required premiums;
- you or your spouse 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. Surviving dependents are generally notified of their rights to continued coverage at the time the Division of Pensions and Benefits is notified of the death of the retiree; however, they may contact the Divisions' Office of Client Services for enrollment forms or for more information. It is imperative that survivors notify the Division as soon as possible after your death because their **dependent coverage terminates the 1st of the month following the date of your death.**

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 "Duration of COBRA Coverage" on page 58), 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, dental, and vision), 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 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 or 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 went into COBRA. This affords a COBRA enrollee the same opportunity to enroll for benefits during the Open Enrollment period as an active employee. 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 or partner ineligible for further dependent coverage).
- Loss of a dependent child's eligibility through the attainment of age 26.

- 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 page 8).

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.

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 a *COBRA Application* within 14 days of receiving notice that a COBRA qualifying event has occurred;

- notify the Division of Pensions and Benefits 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 Division of Pensions and Benefits) that a divorce, legal separation, dissolution of a civil union or same-sex domestic partnership, or death has occurred or that your child has reached age 26 — notification must be given within 60 days of the date the event occurred;
- file a *COBRA Application* with the Division of Pensions and Benefits within 60 days of the loss of coverage or the date of the *COBRA Notice* provided by your employer, whichever is later;
- pay the required monthly premiums in a timely manner; 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.

- First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. The election of continuation of coverage under COBRA may help you to bridge such a gap. (If, after enrolling in COBRA you obtain new coverage which has a pre-existing condition clause, you may continue your COBRA enrollment to cover the condition excluded by the pre-existing condition clause.)
- Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition exclusions if you do not continue coverage under COBRA for the maximum time available to you.
- Finally, 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 or 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 (unless a pre-existing clause applies);
- you voluntarily cancel your coverage;
- your employer drops out of the SHBP or SEHBP;
- you become eligible for Medicare after you elect COBRA coverage. (This affects health insurance only, not dental, prescription, or vision coverage.)

SPECIAL PLAN PROVISIONS

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Effective October 21, 1998, the State Health Benefits Commission adopted as policy, the federal mandate "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 Program 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 Primary Care Physician, pre-certifications, 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.

Please note: If you are covered by the Retired Group and Medicare is primary for you and/or your spouse or eligible 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 handbook 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.

Please 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.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

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.

Mental Health Parity Act Requirements

The State Health Benefits Commission has filed an exemption from the mental health parity requirement with the federal Centers for Medicare and Medicaid Services for calendar year 2012. The visit limits for mental health benefits under NJ DIRECT and the HMO plans will not change. Visit limits for mental health benefits are outlined in the medical plan member handbooks.

All Program health plans meet or exceed the federal requirements with the exception of mental health parity. Parity requires that visit limits on mental health benefits are not lower than those of medical or surgical benefits.

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 Program makes every effort to safeguard the health information of its members and complies with the privacy provisions of HIPAA, which requires that health plans maintain the privacy of any personal information relating to a members' physical or mental health. See page 72 for the *Notice of Privacy Practices*.

NOTICE OF PROVIDER TERMINATION

Any person enrolled in an HMO must be provided with 90-days notice if that person's Primary Care Physician (PCP) will be terminated from the provider network. If 90-day notice cannot be provided, the HMO 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 Division of Pensions and Benefits performs an audit using a random 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;
- 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 (1) year (180 days for HMOs) following your receipt of the plan's initial adverse benefit determination. Consult the appropriate member handbook 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 Appeal External Review (Third Level Appeal)

Medical Appeals for services incurred before January 1, 2012 will be referred to the State Health Benefits Commission/School Employees' Health Benefits Commission (Commission) as appropriate. Refer to the appropriate member handbook for submitting appeals to the Commissions.

Medical Appeals for services incurred on or after January 1, 2012, except for dental appeals, may be requested through your medical or prescription drug plan. Third level dental appeals will continue to be heard by the Commission. Appeal requests for an Independent Review Organization (IRO) review must be submitted within four (4) 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, Dental, and Prescription Drug 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 (1) year following your receipt of the initial adverse ben-

enefit 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
- Hearing Aid for a 60 year old member
- Dispensing limits of a prescription drug

The member or member's legal representative must appeal in writing to the Commission. 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 Commission consideration must contain the reason, in detail, for the disagreement along with copies of all relevant correspondence and should be directed to:

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

Notification of all Commission decisions will be made in writing to the member. If the Commission denies the member's appeal, the member will be informed of further steps he or she may take in the denial letter from the Commission. Any member who disagrees with the Commission's decision may request, within 45 days, in writing to the Commission that the case be forwarded to the Office of Administrative Law. The Commission will then determine if a factual hearing is necessary. If so, the case will be forwarded to the Office of Administrative Law. An Administrative Law Judge will hear the case and make a recommendation to the Commission, which the Commission 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 Office of Administrative Law, 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.

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.
- Member packets must include a Schedule of Benefits which will provide a list of covered services, benefit limitations and benefit exclusions, and appropriate definitions.
- 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 Primary Care Providers (PCP) 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.
- 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;
 - one year from the date the person's coverage under the SHBP or SEHBP ends;

- the date the person has received the maximum benefits under the HMO plan for the disabling condition; or
- 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:
 - a) 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;
 - b) serious impairment to bodily function; or
 - c) 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 Health Maintenance Organization. All procedures performed during the evaluation (triage) and treatment of an emergency medical condition shall be covered by the Health Maintenance Organization.

Minimum Coverage Requirements

Benefit standards include:

- Routine office visit copayments.
- All plans will cover chiropractor visits up to a maximum of 20.
- \$100 will be the maximum annual coinsurance for medical appliances and durable medical equipment.
- 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.

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

Mental Health and Alcohol/Substance Abuse

- There will be no copayment charged for outpatient drug and alcohol rehabilitation treatment.
- All plans will use standard treatment criteria established by the American Society of Addictive Medicine (ASAM).
- Following a detoxification patients may be eligible for up to 28 days of inpatient rehabilitation per occurrence.
- Biologically-based mental health 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, PO Box 325, Trenton, NJ 08625-0325, or call 1-800-446-7467. The report is also available over the Internet at: www.state.nj.us/dobi

New Jersey Hospital Performance Report

Available at the Department of Health and Senior Services Web site 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 over the Internet at: www.state.nj.us/health

REQUIRED DOCUMENTATION FOR DEPENDENT ELIGIBILITY AND ENROLLMENT

The State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) are required to ensure that only employees, retirees, and their eligible dependents are receiving health care coverage under the programs. As a result, the Division of Pensions and Benefits must guarantee consistent application of eligibility requirements within the plans. Employees or Retirees who enroll dependents for coverage (spouses, civil union partners, domestic partners, children, disabled dependents, and over age children continuing coverage) must submit supporting documentation in addition to the appropriate health benefits application.

New Jersey residents can obtain records from the State Bureau of Vital Statistics and Registration Web site: www.state.nj.us/health/vital/index.shtml To obtain copies of other documents listed on this chart, contact the office of the Town Clerk in the city of the birth, marriage, etc., or visit these Web sites: www.vitalrec.com or www.studentclearinghouse.org

DEPENDENT	ELIGIBILITY DEFINITION	REQUIRED DOCUMENTATION
SPOUSE	A person of the opposite sex to whom you are legally married.	A photocopy of the <i>Marriage Certificate</i> and a photocopy of the front page of the employee/retiree's most recently filed federal tax return* (<i>Form 1040</i>) that includes the spouse. If filing separately, submit a copy of both spouses' tax returns.
CIVIL UNION PARTNER	A person of the same sex with whom you have entered into a civil union.	A photocopy of the <i>New Jersey Civil Union Certificate</i> or a valid certification from another jurisdiction that recognizes same-sex civil unions and a photocopy of the front page of the employee/retiree's most recently filed NJ tax return* that includes the partner or a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partner's and is received at the same address.
DOMESTIC PARTNER	A person of the same sex with whom you have entered into a domestic partnership as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act. The domestic partner of any State employee, State retiree, or any eligible employee or retiree of a SHBP/SEHBP participating local/public entity, who adopts a resolution to provide Chapter 246 health benefits, is eligible for coverage.	A photocopy of the <i>New Jersey Certificate of Domestic Partnership</i> dated prior to February 19, 2007 or a valid certification from another State of foreign jurisdiction that recognizes same-sex domestic partners and a photocopy of the front page of the employee/retiree's most recently filed NJ tax return* that includes the partner or a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partner's and is received at the same address.

***Note:** On tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.

DEPENDENT	ELIGIBILITY DEFINITION	REQUIRED DOCUMENTATION
CHILDREN	<p>A subscriber's child until age 26, <i>regardless</i> of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his or her parents.</p> <p>This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation.</p>	<p>Natural or Adopted Child – A photocopy of the child's birth certificate showing the name of the employee/retiree as a parent.</p> <p>Step Child – A photocopy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent and a photocopy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner.</p> <p>Legal Guardian, Grandchild, or Foster Child – Photocopies of Final Court Orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the covered employee.</p>
DEPENDENT CHILDREN WITH DISABILITIES	<p>If a covered child is not capable of self-support when he or she reaches age 26 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuance of coverage. See "Dependent Children with Disabilities" on page 8 for additional information. You will be contacted periodically to verify that the child remains eligible for continued coverage.</p>	<p>Documentation for the appropriate "Child" type (as noted above) and a photocopy of the front page of the employee/retiree's most recently filed federal tax return* (<i>Form 1040</i>) that includes the child.</p> <p>If Social Security disability has been awarded, or is currently pending, please include this information with the documentation that is submitted.</p> <p>Please note that this information is only verifying the child's eligibility as a dependent. The disability status of the child is determined through a separate process.</p>
CONTINUED COVERAGE FOR OVER AGE CHILDREN	<p>Certain children over age 26 may be eligible for continued coverage until age 31 under the provisions of Chapter 375, P.L. 2005. See "Over Age Children until Age 31" on page 8 for additional information.</p>	<p>Documentation for the appropriate "Child" type (as noted above), and a photocopy of the front page of the child's most recently filed federal tax return* (<i>Form 1040</i>), and if the child resides outside of the State of New Jersey, documentation of full time student status must be submitted.</p>

***Note:** On tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.

NOTICE OF PRIVACY PRACTICES TO ENROLLEES

State Health Benefits Program School Employees' Health Benefits Program

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Protected Health Information

The State Health Benefits Program and School Employees' Health Benefits Program (Program) are required by the federal Health Insurance Portability and Accountability Act (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 Protected Health Information (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 Program through various sources, such as enrollment forms, employers, health care providers, federal and State agencies, or third-party vendors.

The Program is 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 Program is 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 Program 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 provided below. This list is illustrative only and not every use and disclosure in a category is listed.

- The Program may disclose PHI to a doctor or a hospital to assist them in providing a member with treatment.
- The Program may use and disclose member PHI so that our Business Associates may pay claims from doctors, hospitals, and other providers.
- The Program receives 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 Program and/or our Business Associates may use and disclose PHI to investigate a complaint or process an appeal by a member.

- The Program 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 Program may use PHI to bill the member for the appropriate premiums and reconcile billings we receive from our Business Associates.
- The Program may use and disclose PHI for fraud and abuse detection.
- The Program 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 Program may use and disclose PHI in response to a court or administrative order as provided by law.
- The Program 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 Program 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 Program will provide access to PHI only to the member, the member's authorized representative, and those organizations who need the information to aid the Program in the conduct of its business (our "Business Associates"). An authorization form may be obtained over the Internet at: www.state.nj.us/treasury/pensions or by sending an e-mail to: hipaafom@treas.state.nj.us. A member may revoke an authorization at any time.

When using or disclosing PHI, the Program 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 Program maintains physical, technical and procedural safeguards that comply with federal law regarding PHI.

Member Rights

Members of the Program 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 Program maintains in a designated record set which consists of all documentation relating to member enrollment and the Program's 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 Program 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, please contact your 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 Program 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 Program; 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 Program or our Business Associates have disclosed member PHI. The accounting will review disclosures made over the past six years or back to April 14, 2003, whichever period is shorter. 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 Program place restrictions on the use or disclosure of their PHI for treatment, payment, or health care operations purposes. The Program is 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 Request Confidential Communications: The member has the right to request that the Program 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 Program 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.

Questions and Complaints

If you have questions or concerns, please contact the Program 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 Program 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 Program communicate with them in confidence by alternative means or at an alternative location, they must submit their complaint in writing. To obtain a form for submitting a complaint, use the contact information found at the end of this Notice.

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

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

Contact Office: The Division of Pensions and Benefits
HIPAA Privacy Officer

Address: Division of Pensions and Benefits
Bureau of Policy and Planning
PO Box 295
Trenton, NJ 08625-0295

Fax: (609) 341-3412

E-mail: hipaaform@treas.state.nj.us

HEALTH BENEFITS CONTACT INFORMATION

Health and Dental plan telephone numbers and mailing addresses are located in the individual plan descriptions (beginning on page 20 for medical plans and page 34 for dental plans).

ADDRESSES

Our Mailing Address is Division of Pensions and Benefits
PO Box 299
Trenton, NJ 08625-0299

Our Internet Address is www.state.nj.us/treasury/pensions/health-benefits.shtml

Our E-mail Address is pensions.nj@treas.state.nj.us

TELEPHONE NUMBERS

Division of Pensions and Benefits:

Office of Client Services (609) 292-7524

TDD Phone (Hearing Impaired) (609) 292-7718

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 Personnel Counseling Service

Employee Advisory Program (EAP) (732) 932-7539

University of Medicine and Dentistry of New Jersey

Employee Advisory Program (EAP) (973) 972-5429

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 and Senior Services

Division of Aging and Community Services 1-800-792-8820

Insurance Counseling 1-800-792-8820

Independent Health Care Appeals Program (609) 633-0660

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 Division of Pensions and Benefits provide information on a variety of subjects. Fact sheets, handbooks, applications, and other publications are available for viewing or downloading over the Internet at: www.state.nj.us/treasury/pensions

General Publications

Plan Comparison for State Employees

Plan Comparison for Local Government Employees

Plan Comparison for Local Education Employees

Plan Comparison for All Retirees

Health Benefit Fact Sheets

Fact Sheet #11, Enrolling in the Health Benefits Coverage When you Retire

Fact Sheet #23, Health Benefits and Medicare Parts A & B for Retirees

Fact Sheet #25, Employer Responsibilities under COBRA

Fact Sheet #26, Health Benefits Options upon Termination of Employment

Fact Sheet #30, The Continuation of Health Benefits Coverage under COBRA

Fact Sheet #31, Benefits at Termination of Employment through registration, Dismissal or Layoff

Fact Sheet #37, Employee Dental Plans

Fact Sheet #47, Retired Health Benefits Coverage under Chapter 330 - PFRS & LEO

Fact Sheet #48, Family Status Changes - Employees

Fact Sheet #49, Family Status Changes - Retirees

Fact Sheet #51, Continuing Health Benefits Coverage for Over Age Children with Disabilities

Fact Sheet #66, Health Benefits Coverage for Part-Time Employees

Fact Sheet #69, SHBP Coverage for State Intermittent Employees

Fact Sheet #71, Benefits under the Domestic Partnership Act

Fact Sheet #73, Retiree Dental Expense Plan

Fact Sheet #74, Health Benefits Coverage of Children until Age 31 under Ch. 375, P.L. 2007

Fact Sheet #75, Civil Unions

Health Plan Member Handbooks

NJ DIRECT Member Handbook

Aetna Member Handbook

Cigna Member Handbook

Prescription Drug Plans Member Handbook

Employee Dental Plans Member Handbook

Retiree Dental Expense Plan Member Handbook

NOTES

