

**NEW JERSEY**

**STATE  
HEALTH BENEFITS  
PROGRAM**

***SUMMARY  
PROGRAM  
DESCRIPTION***

**FOR EMPLOYEES AND RETIREES**

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

**PLAN YEAR 2007**



The following information supplements the  
*SHBP Summary Program Description,*  
*NJ PLUS Member Handbook,*  
*Traditional Plan Member Handbook,*  
*HMO Plan Member Handbooks,* and  
*SHBP Employee Prescription Drug Plan Member Handbook*

**Effective July 1, 2007 for State Employees**

The passage of Chapter 103, P.L. 2007, and contract negotiations between the State and the CWA, AFSCME, and IFPTE, have resulted in changes to State Health Benefits Program (SHBP) coverage.

Employees covered under these labor groups, and employees not covered by a labor agreement, who are enrolled in the SHBP as an employee for health and/or prescription drug coverage are required to pay a health care contribution and will have new medical and prescription drug plan copayment amounts.

The contribution and copayment changes are effective July 7, 2007 for State employees paid through the Centralized Payroll Unit and July 1, 2007 for other State employees covered under the agreements.

Additional labor bargaining groups may be added to the employees affected by these changes as pending labor contracts are settled.

**EMPLOYEE CONTRIBUTIONS FROM PAYROLL**

Under the new agreement, State employees will contribute 1.5 percent of annual base salary regardless of the medical plan or level of coverage that is selected.

The previous contract arrangement of State employees sharing 5 percent of an HMO premium, or 25 percent of the Traditional Plan premium, will end.

Employees are permitted to waive SHBP medical *and* prescription coverage to avoid the 1.5 percent contribution from salary — provided the employee has other health care coverage. To waive coverage a *SHBP State Waiver* form and a *SHBP Application* must be completed.

**NJ PLUS AND HMO PLAN COPAYMENTS**

For NJ PLUS and all HMOs (Aetna, AmeriHealth, CIGNA, Health Net, and Oxford), the copayment for a primary doctor visit or a visit to a specialist is \$15.

The copayment for a visit to an emergency room is \$50. The emergency room copayment is waived if you are admitted to the hospital.

## **EMPLOYEE PRESCRIPTION DRUG PLAN COPAYMENTS**

The Employee Prescription Drug Plan has been modified to include a third tier of copayments.

The copayment for each 30-day supply when purchased at a retail pharmacy is \$3 for generic drugs (first tier) and \$10 for brand name prescription drugs without generic equivalents (second tier). **The new third tier includes a \$25 copayment for brand name drugs where a generic equivalent is available.**

Mail order prescription drug copayments for up to a 90-day supply are \$5 for generic drugs (first tier) and \$15 for brand name drugs without generic equivalents (second tier). **The third tier mail order copayment is \$40 for brand name drugs where a generic equivalent is available.**

### **Third Tier Copayment Exception**

If it can be established that a patient either has an intolerance to a drug's generic equivalent **or** there is a therapeutic failure of the generic equivalent, a member may be permitted to obtain a third tier brand name prescription drug *with a generic equivalent* for the lower second tier copayment of a brand name prescription drug *without* a generic equivalent.

In these cases, the physician must provide sufficient documentation to Horizon Blue Cross Blue Shield of New Jersey to support the intolerance or therapeutic failure of the generic equivalent. The physician should complete the U.S. Food and Drug Administration's *MedWatch Form* or submit similar medical record information that documents the finding, and forward it to Horizon for consideration.

During Horizon's review process, the member will still be able to obtain the prescription by paying the higher copayment. If Horizon approves the request, the member will be reimbursed the difference in the copayment amounts. If the request is denied, the member can appeal that decision through Horizon's appeal procedure.

## **SHBP COVERAGE FOR STATE RETIREES**

There are no changes to premium sharing arrangements for current retirees at this time.

In addition, the copayment changes for visits to a doctor, a specialist, or emergency room, and for prescription drugs do not apply to current retirees at this time. Please see the retiree information in your plan's member handbook for copayment details.

Under the provisions of Chapter 103, 2007, changes to retired SHBP coverage for employees who attain 25 years of service *on or after* July 1, 2007 will be addressed after the establishment of a "wellness plan" that is scheduled to begin operation sometime in the 2008 plan year.

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

**PLAN YEAR 2007**

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## INTRODUCTION

The State Health Benefits Program (SHBP) was originally established in 1961. It offers medical, prescription drug, and dental coverage to qualified public employees and retirees, and their eligible dependents. The State Health Benefits Program Act is found in the New Jersey Statutes Annotated, Title 52, Article 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 State Health Benefits Commission (SHBC) is the executive organization responsible for overseeing the State Health Benefits Program (SHBP). The SHBC includes the State Treasurer as the chairperson, the Commissioner of the Department of Banking and Insurance, the Commissioner of the Department of Personnel, a State employee representative chosen by the Public Employees' Committee of the AFL-CIO, and a representative chosen by the New Jersey Education Association (NJEA), or their designated representatives. The Director of the Division of Pensions and Benefits is the Secretary to the SHBC. The Division of Pensions and Benefits, specifically the Health Benefits Bureau and the Bureau of Policy and Planning, is responsible for the daily administrative activities of the SHBP.

Every effort has been made to ensure the accuracy of this *Summary Program Description*, which describes eligibility for, and the benefits provided through, the SHBP. However, State law and the New Jersey Administrative Code govern the SHBP. **If there are discrepancies between the information presented in this booklet and/or plan documents and the law, regulations, or contracts, the latter will govern.**

An online version of this booklet containing current updates is available for viewing over the Internet at: [www.state.nj.us/treasury/pensions/shbp.htm](http://www.state.nj.us/treasury/pensions/shbp.htm) Be sure to check the Division of Pensions and Benefits Internet home page at: [www.state.nj.us/treasury/pensions](http://www.state.nj.us/treasury/pensions) for SHBP related forms, fact sheets, and news of any new developments affecting the benefits provided under the SHBP.

The purpose of this *Summary Program Description* is to provide you with information about the SHBP that can assist you in making informed health care decisions for you and your family. 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](mailto:pensions.nj@treas.state.nj.us) Refer to page 65 for information on contacting the SHBP and its related health services.

## **RECENT BENEFIT CHANGES**

### **GENERAL CHANGES**

#### **Temporary Voluntary Furlough “Rule Relaxation” (State Employees Only)**

The Department of Personnel Merit System Board issued a “rule relaxation” extending through June 30, 2007. During this period, a State employee can take unlimited furlough, if approved by their employer, without loss of employer paid health benefits. Unless subsequently extended, as of July 1, 2007 the “rule relaxation” will cease and health benefits will only be covered for up to 30 days of furlough (Chapter 297, P.L. 1993).

#### **Coverage for Over Age Children to Age 30**

Chapter 375, P.L. 2005, provides for medical and/or prescription drug coverage for an over age child by blood or law who is under the age of 30; 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 is responsible for the entire cost of coverage. There is no provision for eligibility for dental or vision benefits.

### **MEDICAL AND PRESCRIPTION DRUG PLAN CHANGES**

#### **Copayments for Local Government and Educational Employees and All Retirees**

**Effective January 1, 2007** copayment amounts for Local Government and Educational Employees, all Retirees, and covered dependents have been revised.

**All SHBP covered employees and retirees** enrolled in **NJ PLUS** or an **HMO plan** have a \$10 copayment amount for primary doctor visits and visits to a specialist.

**All employees** enrolled in the **Employee Prescription Drug Plan** have a copayment of \$3 for generic drugs and \$10 for brand name prescription drugs for each 30 day supply received at a retail pharmacy. Mail order copayments for up to a 90-day supply will be \$5 for generic drugs and \$15 for brand name prescription drugs.

**Retirees** enrolled in the **Traditional Plan** or **NJ PLUS** have a copayment of \$8 for generic drugs, \$17 for preferred brand name drugs, and \$34 for all other brand name drugs for each 30 day supply purchased at a retail pharmacy. Mail order copayments for up to a 90-day supply are \$8 for generic drugs, \$25 for preferred brand name drugs, and \$42 for all other brand name drugs. Also effective January 1, 2007, the annual maximum out-of-pocket for prescription drug copayments is \$1,082 per person. Once a person has paid \$1,082 in copayments, that person is no longer required to pay any prescription drug copayments for the remainder of that calendar year.

# STATE HEALTH BENEFITS PROGRAM ELIGIBILITY

## ACTIVE EMPLOYEE ELIGIBILITY

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

### 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 normally requires 35 hours per week.

The following categories of employees are also eligible for coverage.

**State Part-Time Employees** — Part-time employees of the State and part-time faculty at institutions of higher education that participate in the SHBP are eligible for coverage under NJ PLUS and the Employee Prescription Drug Plan if they are members of a State-administered pension system. The employee or faculty member must pay the full cost of the coverage. Part-time employees 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 they were covered by the SHBP up to the date of retirement. See Fact Sheet #66, *SHBP Coverage for State Part-Time Employees*, for more information.

**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 PLUS and/or the Employee Prescription Drug Plan. 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 more information.

**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 PLUS and the Employee Prescription Drug Plan at the State's expense. Upon enrollment, the member may also enroll eligible dependents. The Department of Military and Veteran's Affairs is responsible for notifying eligible members and for notifying the Division of Pensions and Benefits of members who are eligible.

**State Employees Enrolled On or After July 1, 2003** — Certain State employees who enroll in the SHBP on or after July 1, 2003 are not eligible for coverage under the Traditional Plan. This group includes State employees as determined by union contract and all non-aligned State employees as provided under Chapter 119, P.L. 2003. See your human resources representative for information about your union affiliation.

**Fraternal Order of Police and State Police Units** — Employees in State law enforcement bargaining units (most Fraternal Order of Police units, see note on page 4, and all

State Police units including non-aligned officers) cannot participate in the SHBP Traditional Plan effective July 1, 2005.

**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. Each participating local employer defines the minimum hours required for full-time by a resolution filed with the SHBP, but it can be no less than an average of 20 hours per week. 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 SHBP is eligible for coverage under NJ PLUS — and if provided by the employer, the Employee Prescription Drug Plan — if they are members of a State-administered pension system. The faculty member must pay the full cost of the coverage. Part-time faculty members 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 they were covered by the SHBP up to the date of retirement. See Fact Sheet #66, *SHBP Coverage for State Part-Time Employees*, for more information.

### ELIGIBLE DEPENDENTS

Your eligible dependents are your spouse or eligible same-sex domestic partner (as defined below) and/or your eligible unmarried children (as defined below).

**Spouse** — This is a member of the opposite sex to whom you are legally married. A photocopy of the marriage certificate is required for enrollment.

**Domestic Partner** — This is a same-sex domestic partner, as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act, of any State employee, State retiree, or an eligible employee or retiree of a SHBP participating local public entity if the local governing body adopts a resolution to provide Chapter 246 health benefits (see also, “Chapter 334” on page 8). A photocopy of the New Jersey *Certificate of Domestic Partnership* (or a valid certification from another jurisdiction that recognizes same-sex domestic partners, civil unions, or similar same-sex relationships) is 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** — This includes your unmarried children under age 23 who live with you in a regular parent-child relationship, your children who are away at school, as well as divorced children living at home provided that they are dependent upon you for support and maintenance. If you are a single parent, divorced, or legally separated, your children who do not live with you are eligible if you are legally required to support those children. *Affidavits of*

**Dependency and** legal documentation are required with enrollment forms for these cases. If a Qualified Medical Child Support Order (QMCSO) is issued for your child, the health plan of the parent named in the QMCSO will be the primary plan for that child. The employer must be notified of the QMCSO and a *NJ State Health Benefits Program Application* submitted electing coverage for the child within 60-days of the date the order was issued.

Stepchildren, foster children, legally adopted children, and children in a guardian-ward relationship are also eligible provided they live with you and are substantially dependent upon you for support and maintenance. *Affidavits of Dependency* and legal documentation are required with enrollment forms for these cases.

Coverage for an enrolled child will end when the child marries, enters into a domestic partnership, moves out of the household, turns age 23, or is no longer dependent on you for support and maintenance. Coverage for children age 23 ends on December 31 of the year in which they turn age 23 (see the “COBRA” section on page 45 and “Over Age Children to Age 30” below for continuation of coverage provisions).

**Dependents with Disabilities** — If a child is not capable of self-support when he or she reaches age 23 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 23, 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, 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. You will be contacted periodically to verify that the child remains eligible for continued coverage.

**Over Age Children to Age 30** — Certain over age children may be eligible for coverage until age 30 under the provisions of Chapter 375, P.L. 2005. This includes a child by blood or law who is under the age of 30; 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 is responsible for the entire cost of coverage. There is no provision for eligibility 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.

## MEDICARE COVERAGE WHILE EMPLOYED

In general, it is not necessary for a Medicare-eligible employee, spouse, eligible same-sex domestic 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 Stage 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 “Medicare Eligibility” beginning on page 40 in the “Retiree Enrollment” section.

## **RETIREE ELIGIBILITY**

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

- Full-time State employees, employees of State colleges/universities, autonomous State agencies and commissions, or local employees who were covered by, or eligible for, the SHBP at the time of retirement.
- Part-time State employees and part-time faculty at institutions of higher education that participate in the SHBP if enrolled in the SHBP at the time of retirement.
- 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 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 SHBP. This includes those who elect to defer retirement with 25 or more years of service credit in one or more State or locally-administered retirement system (see "*Aggregate of Service Credit*" on page 8).
- 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 service credit from an employer that participates in the SHBP.
- Full-time members of the TPAF and 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 Parts A and 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.
- Certain local policemen or firemen with 25 years or more of service credit in the pension fund 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, *SHBP Retired Coverage Under Chapter 330*, for more information.
- Surviving spouses, 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.

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

1. You must be immediately eligible for a retirement allowance from a State- or locally-administered retirement system (except certain employees retiring from a school board or community college — or certain disability retirees, see page 8); and

2. You were a full-time employee and eligible for employer-paid medical coverage immediately preceding the effective date of your retirement (if you are an employee retiring from a school board or community college under a deferred retirement with 25 or more years of service, you must have been eligible at the time you terminated your employment), or a part-time State employee or part-time faculty member or who is enrolled in the SHBP immediately preceding the effective date of your retirement.

This means that 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 of the SHBP. (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 45 for an explanation of COBRA) — or as a dependent under other coverage through a public or private employer — until your retirement becomes effective, you will be eligible for retired coverage under the SHBP.

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 of the SHBP 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 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 State-paid health benefits under the SHBP. 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 employer-paid health benefits under the SHBP. Effective August 15, 2001, instead of having to meet the 25-year service credit requirement from a **single** State or locally-administered retirement system, a retiree under the SHBP 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 nonconcurrent.

### **Eligible Dependents of Retirees**

Dependent eligibility rules for Retired Group coverage are the same as for Active Group coverage (see page 4) except for Chapter 334 domestic partners described below and the Medicare requirements discussed on page 40.

**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 in SHBP, but who are become eligible for SHBP coverage at retirement (see page 7), may also enroll a registered same-sex domestic partner as a covered dependent provided that the former employer's non-SHBP plan includes domestic partner coverage for employees.

### **Enrolling in the Retired Group of the SHBP**

The SHBP 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 the SHBP's Retired Group coverage. Early filing for retirement is recommended to prevent any lapse of SHBP coverage or delay of eligibility.

**Additional restrictions and/or requirements may apply when enrolling in the Retired Group of the SHBP.** Be sure to carefully read the "Retiree Enrollment" section that begins on page 39 of this booklet.

# CHOOSING A STATE HEALTH BENEFITS PROGRAM PLAN

The SHBP offers 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 health plans, dental plans, and prescription drug coverage.

## SHBP HEALTH PLANS

### CHOOSING A HEALTH PLAN

Choosing a health plan is an important decision and one that requires careful consideration. Because there is no single best plan, the SHBP offers a selection of quality health plans\*. These plans fall under one of three basic types: the indemnity style **Traditional Plan**, one of several **Health Maintenance Organizations** (HMOs), or **NJ PLUS**, a point-of-service plan — which is a blend of HMO and indemnity coverage.

To select a health plan that meets your needs, and those of your dependents, review the information available to you in this booklet, any additional information available from the health plans, and consider the following factors:

### COVERAGE

Each SHBP health plan offers a variety of services. For example: some plans cover preventive and wellness services while others do not. While many services are the same from plan to plan, many others 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.

To help with comparing health plan services, the SHBP creates the *SHBP Comparison Summary* chart. To obtain a copy of the chart, see your employer or refer to page 66 for information about obtaining SHBP related publications. The comparison information is also available over the Internet at: [www.state.nj.us/treasury/pensions/shbp.htm](http://www.state.nj.us/treasury/pensions/shbp.htm)

Additional plan information is also available by calling the plans that you are interested in. Telephone numbers, addresses, and Internet addresses are found in each plan description beginning on page 13.

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**\*Note:** State Part-time and Intermittent employees, and New Jersey National Guard enrollees, are restricted to enrollment in NJ PLUS and/or the Employee Prescription Drug Plan (see page 3). Certain State employees hired on or after July 1, 2003 are prohibited from enrolling in the Traditional Plan (see page 4).

As of July 1, 2005, employees in the State law enforcement bargaining units (most Fraternal Order of Police units and all State Police units including non-aligned officers) cannot participate in the Traditional Plan (see page 3).

## CHOICE OF PROVIDER

The **Traditional Plan** allows you to use any licensed medical provider or hospital facility. Should you need specialist care, you may also choose to use any licensed specialist. Benefits are payable subject to deductibles and coinsurance.

The **HMOs** offer a list of participating providers from which you may select a Primary Care Physician (PCP). That physician coordinates all your care. Unless your HMO allows open access to participating specialists, 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.

**NJ PLUS** is a point-of-service plan, meaning you decide which provider to use when you need a service. NJ PLUS has in-network benefits which apply when you select and use a primary care physician from the list of participating providers. As with an HMO, all care is coordinated through your PCP. Referrals must be obtained from your PCP in order for you to visit a specialist. NJ PLUS also offers 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 copayment. Out-of-network benefits are payable subject to a deductible and coinsurance.

### 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 to request a provider directory or check the plan's Web site for a listing of the participating physicians.

The SHBP also offers the **Unified Provider Directory (UPD)**. Updated monthly, the UPD is available over the Internet and contains information about health care providers and facilities that deliver their services through one or more of the SHBP's managed-care plans in New Jersey and selected areas of neighboring states (for other states, contact the plan for provider information). The information is in an easy to use format and can be reached through the SHBP's home page at: [www.state.nj.us/treasury/pensions/shbp.htm](http://www.state.nj.us/treasury/pensions/shbp.htm)

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

## CONVENIENCE

Some health plans may have certain providers who are affiliated with hospitals that are more convenient to your home or workplace. It is important to consider the hospital affiliation of your selected provider as well as the location of the provider's office. This information can be obtained from the health plan, the Unified Provider Directory (see above), or by contacting the provider directly.

## COST

Depending upon your employer's benefit policies or agreements with the labor organization (union) representing you, you may be required to pay premiums or share in the cost of your health plan. Check with your human resources representative or benefit administrator to determine if you are required to pay any portion of the cost of your health care.

The **Traditional Plan** and **NJ PLUS out-of-network** benefits require that an annual deductible be met, and services are reimbursed subject to coinsurance based on reasonable and customary allowance for the service. Therefore, when you are enrolled in the Traditional Plan or utilizing NJ PLUS 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 for that service or the plan payment to the provider.

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

**HMOs** and **NJ PLUS in-network** benefits require copayments for routine services such as office visits, use of emergency rooms, etc. When using an HMO or NJ PLUS in-network there is no deductible or coinsurance and reasonable and customary charges do not apply.

## **PLAN DESCRIPTIONS**

The information on the following plan description pages is supplied by each individual health plan and intended to provide a brief overview of the plan and the benefits it offers. **If there are discrepancies between the information presented in these pages and the law, regulations, or contracts, the latter will govern.**

**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 State Health Benefits Program, Division of Pensions and Benefits, PO Box 299, Trenton, NJ 08625-0299.

We want you to know<sup>SM</sup>



**You can enjoy all the benefits of an Aetna HMO or Elect Choice Plan such as:** routine checkups; hospitalization and surgery; Emergency Care - anytime, anywhere; specialty care; diagnostic testing; vision services.

**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 in Connecticut, Delaware, Maine, New Jersey, Pennsylvania, Washington DC; and parts of Arizona, Florida, Georgia, Illinois, Indiana, Maryland, Massachusetts, Nevada, New Hampshire, New York, North Carolina, Ohio, Tennessee, Texas, Virginia, and Washington can access our networks of quality providers.

**Aetna's HMO for Active Employees and Early Retirees; Elect Choice<sup>TM</sup> for Medicare Eligible Retirees** - Both plans offer quality coverage with the added benefit of *low out-of-pocket costs*. There are no claim forms to fill out and no deductibles to pay. Each covered member of your family must select a participating Primary Care Physician (PCP) to coordinate their care. The PCP may be either an internist, family doctor, pediatrician, or general practitioner. You may change your PCP selection at any time by calling member services or via Aetna Navigator. PCPs provide routine care for illness, injury and preventive care such as periodic physical examinations, eye exams, well-baby visits and immunizations. Members are responsible for a copayment for each visit.

**Medicare Eligible Retirees** enrolled in Aetna and their dependents who are eligible for Medicare will be enrolled in Aetna Life Insurance Company's Elect Choice Plan. They will have the same benefits, the same copayments, and with a few exceptions, the same providers as those enrolled in the HMO plan, but Medicare will be the primary payer. Retirees enrolled in this plan will receive an identification card that indicates they are in the **Elect Choice Plan**. You should present your Medicare identification card and your Elect Choice card when receiving medical services.

**Electronic Referrals** - Your PCP may refer you to a network **specialist** as part of your treatment

plan. Under both plans you will need to obtain a referral from your PCP to visit the specialist and you will be responsible for a set copayment for each referred visit. **Electronic referrals** are available in some PCP offices. Where 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.

**Open Access Gynecology Program** - Female 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.

**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 HMO service area or students who are away at school are covered for emergency and urgently needed care.

**Aetna Navigator<sup>TM</sup>** - 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 wherever 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](http://www.aetna.com).

**DocFind<sup>®</sup>** - It's easy to choose a Primary Care Physician (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 loca-

tion, medical specialty, hospital affiliation, and/or languages spoken. In addition, you can obtain maps, driving directions, and physician performance summaries. DocFind is updated three times a week, giving you access to the most up-to-date list of participating providers. To use DocFind, simply go to [www.aetna.com](http://www.aetna.com). If you need a paper directory, call the Member Services number on the back of your ID card.

**Healthy Outlook Program** - If you have a chronic condition, such as asthma, diabetes, chronic heart failure, or coronary artery disease, the Healthy Outlook Program gives you tools to prevent or delay complications, increase confidence in managing your condition and improve the overall quality of your life.

**Prescription Drug Coverage** - Outpatient prescription drugs, including insulin, are covered. Each prescription is limited to a maximum 30-day retail supply, with up to five refills when authorized. There is a copayment per 30-day prescription or per refill of \$5 for covered generic drugs, \$10 for covered preferred brand name drugs, and \$20 for all other covered brand name drugs. A mail order pharmacy program is also available to obtain up to a maximum 90-day supply of covered medications. Mail order copayments are \$5 / \$15 / \$25 for the same three categories of drugs described above. All prescription drugs are not covered under the plan. Refer to your plan documents and the formulary guide to determine limitations and exclusions under the plan. You may also call Member Services or log on to our Web site to inquire about coverage of a particular drug prior to enrollment. (Prescription coverage through Aetna may not be applicable to all employees).

**Vision One®** - You are eligible to receive substantial discounts on eyeglasses, contact lenses, and additional vision-related items through the

Vision One Program at more than 13,000 locations nationwide. The program also includes a discount on Lasik surgery. For more details about the Vision One 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. EST.

**Member Health Information** - 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.

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

◆ **Natural Alternatives** 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.

**Women's Health for Life Programs** - Aetna is committed to providing a variety of services and education emphasizing issues and concerns shared by women through all stages of their life. We include programs in our HMO plan that support women's unique health care needs. See our Web site for more information [www.aetna.com](http://www.aetna.com).

Active Employees and Early-Retirees can contact Member Services at 1-800-309-2386.  
Retirees with Medicare can contact Member Services at 1-800-345-4432.  
Customer Service Representatives are available weekdays to answer your questions 8 a.m. to 6 p.m. EST Monday to Friday.  
You may also access our Web site at [www.aetna.com](http://www.aetna.com)

"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.

# AmeriHealth HMO

The Health Plan with You in Mind



## Committed to New Jersey

At AmeriHealth, we are focused on our members' needs. With nearly 10 years as a local insurer, AmeriHealth provides New Jersey participants with a variety of programs and services designed to keep you in the best of health. With AmeriHealth, you get more than just access to health care benefits. We offer information, tools, and resources you can use to make informed health care decisions.

## Network

AmeriHealth HMO offers one of the largest provider networks in New Jersey with over 10,000 primary care physicians, more than 29,000 specialists, and 238 hospitals. Our network includes providers from many medical fields in every county in New Jersey, Delaware, and Southeastern Pennsylvania. When you carry an AmeriHealth card, your health care coverage extends beyond your local service area. Away at school, on business, or pleasure - AmeriHealth HMO participants have access to health care benefits for unexpected illness or emergency care no matter where you are. Whatever the reason, you'll have peace of mind knowing you have access to the care you need.

## Quality

AmeriHealth HMO is committed to providing participants with access to quality care, and reviews providers and their credentials before inviting them into our network. In recognition for our efforts, the National Committee for Quality Assurance (NCQA) has awarded AmeriHealth its accreditation status of "Excellent". This is the highest possible accreditation status that a HMO can receive for meeting the rigorous evaluation standards of the NCQA, a non-profit group that accredits managed care organizations.

## Core Benefits and Special Services

AmeriHealth HMO provides coverage for doctor visits, specialty care, hospital services, and out-of-area coverage. Most visits are covered 100% after an applicable copayment. AmeriHealth HMO also provides access to preventive care services, including periodic health assessments, immunizations, routine gynecological care, and well baby/well child care.

AmeriHealth HMO covers most prescription drugs with a retail pharmacy copayment of \$5 for formulary generic drugs, \$10 for formulary brand name drugs, and \$20 for all other non-formulary drugs. A 90-day supply of prescription drugs is available at participating retail pharmacies for three copayments. A 90-day supply is also available by mail order with a copayment of \$5 for formulary generic drugs, \$15 for formulary brand name drugs, and \$25 for non-formulary drugs. Approximately 98% of retail pharmacies locally and 95% of retail pharmacies nationwide participate in the Caremark pharmacy network. Participants do not need to pre-select one pharmacy. (AmeriHealth prescription drug coverage may not be applicable to all employees.)

## AmeriHealth Healthy Lifestyles<sup>SM</sup> Wellness Programs

### Live Healthy!

At AmeriHealth, we like to reward healthy behavior. Want to join a gym, lose weight, or quit smoking? We offer reimbursements for participants who take an active role in improving and maintaining their good health. We also provide discounts for alternative health services and reminders for important health screenings.

### Stay Healthy!

Get the information, guidance, and encouragement you need when dealing with chronic or unexpected health conditions. Our Connections<sup>SM</sup> Health Management Programs provide 24/7 access to a Health Coach, an encyclopedia of health information and educational materials.

For more information on these valuable programs, please log onto *amerihealth.com*.

### Baby FootSteps<sup>®</sup>

Our maternity program is designed to support mothers-to-be throughout their pregnancy and ensure that their new arrival will get the best start in life. It also offers educational materials, up to \$50 reimbursement for any approved prenatal class, as well as a reimbursement of up to \$50 toward the purchase of a breast pump.

### Pediatric Immunization

To help parents ensure their children are fully vaccinated by age two, we send special mailings to parents with a recommended schedule of immunizations. Answers to commonly asked questions and concerns are also included.

### amerihealthexpress.com

At AmeriHealth, you have access to your benefits 24 hours a day, seven days a week. With *amerihealthexpress.com* you can:

- Review your benefits
- Change your PCP
- Locate and compare participating providers including quality and safety information
- Check on claims
- Manage prescription drug benefits such as submitting mail-order refills, checking drug-to-drug interactions, and comparing drug costs
- Request an ID card
- Access an encyclopedia of health information through Health Dialog<sup>®</sup>

#### For Additional Information

<b>Mail</b>	AmeriHealth HMO, Inc. 8000 Midlantic Drive Suite 333 Mt. Laurel, NJ 08054	<b>or</b>	AmeriHealth HMO, Inc. 485 Route 1 South 3 <sup>rd</sup> Floor, Building C Iselin, NJ 08830
<b>Telephone</b>	1-800-877-9829		
<b>Internet</b>	www.amerihealth.com		

This overview is intended to highlight the benefits available. For complete descriptions, including all benefits, limitations, and exclusions, refer to the AmeriHealth HMO Participant Handbook.



*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.

## Quality health care from in-network providers

Our HMO plans give 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
- Six-month 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 Line<sup>SM</sup> 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<sup>®</sup>, you get access to a full range of health and wellness service often not covered by many traditional benefit plans. Programs include:

- Weight Watchers<sup>®</sup>
- QuiteNet and Tobacco Solutions smoking cessation programs
- Chiropractic Care
- Massage Therapy
- Eye exams, frames, and lenses
- Fitness club memberships
- And much more!

**Quality transplant care** — access care from nationally recognized facilities in the CIGNA LIFESOURCE Transplant Network<sup>SM</sup>.

**Support for chronic conditions** — manage your chronic condition with help from CIGNA Well Aware for Better Health<sup>SM</sup>. With programs that provide education support and a wide range of tools, we make it easier for you to take control of:

- asthma
- diabetes
- heart disease
- low back pain

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**Note:** Not all programs are available in all states.

- chronic obstructive pulmonary disease

**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.

**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.

### **Prescription Drugs**

Prescriptions and refills covered up to 30-day supply when purchased at a participating pharmacy. Coverage is provided for generic and brand name drugs as prescribed by your doctor. Coverage is provided for diabetic drugs and supplies and includes insulin, insulin syringes and needles, glucose test strips and lancets. Prenatal vitamins are also covered. Coverage is provided for contraceptive devices and oral fertility drugs. No annual maximum.

<b>Retail Pharmacy</b> Per prescription 30-day supply	<b>Mail Order</b> Per prescription 90-day supply
Generic - \$5	Generic - \$5
Preferred Brands - \$10	Preferred Brands - \$15
All Other Brands - \$20	All Other Brands - \$25

*(Prescription coverage through CIGNA may not be applicable to all employees.)*

### **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**

1-800-CIGNA24 and a CIGNA representative will assist you. Or visit *myCIGNA.com*.

**Access. Support. Choice.  
Flexibility. Wellness.  
A Better Decision.**



When choosing a health plan, you might ask: What should I expect? Good benefits and access to quality care? Of course. But we think a health plan should offer you more. We think every health plan should recognize that injury and illness can affect more than the individual, they can affect family. That the road to recovery often has many milestones and decisions to make. That everyday concerns can become medical ones. We understand these things. It's what sets us apart. Our mission is to help people be healthy, secure and comfortable. And we provide services that help individuals and families when they need it most, in ways that truly matter

What makes Health Net a better decision?

**No referrals needed:** Who knows best when you need specialty care? We think you and your doctor do. That's why we give you open access to participating specialists. Open access means that you're able to see a participating specialist without a referral. Health Net is the only HMO in the State Health Benefits Program that gives you open access to participating specialists. Also, there are no claim forms to fill out and no deductibles.

**Large Seamless Network:** Our seamless Tri-State Advantage Platinum network includes more than 94,000 physician and provider locations in New Jersey, New York, and Connecticut, including more than 27,000 provider office locations in New Jersey alone. We have the hospitals you want, including premiere hospitals like Columbia Presbyterian, Mount Sinai, and New York Hospital.

**Prescription Drug Coverage:** With more than 58,000 pharmacies nationwide in our network, members can fill prescriptions at all major retail chains and many independent, local pharmacies. Our mail order program can provide additional savings by offering you a three-month supply of your prescription for the cost of one slightly higher copayment (call 1-800-441-5741 for details).

**Note:** Prescription drug coverage under Health Net does not apply to those individuals who have coverage through another prescription plan offered by their employer.

**Decision Power™:** With Health Net's Decision Power™, we're there for you when you need us. Whether you're having chest pains at 3 a.m., or need to choose the best course of treatment for a rare condition, Health Net's Decision Power™ has a resource to help you. With live, 24/7 access to caring, professional health coaches, decision support videos, and a wealth of other tools, Decision Power™ helps members become fully informed about their conditions and the options that are available to them. This fully integrated system provides the tools and resources that allow each individual to better communicate with their doctors and choose a personal treatment course that is right for them.

**Access to alternative medical treatments:** More than 30 million Americans receive some form of alternative medical care every year. Health Net members have access to quality chiropractic care and acupuncture, as well as discounts on massage therapy.

**Preventive care to help you stay healthy:** To assure good overall health and early detection of potential problems, we provide coverage for adult and well child exams,

childhood immunizations, regular eye exams and cancer screenings. Our female members are also covered for regular gynecological visits.

**Smart Start<sup>SM</sup>:** We understand how important your children's health is, and how difficult it can be to stay up-to-date with their health care. That's why we offer Smart Start<sup>SM</sup>. This reminder program helps parents keep track of their children's immunizations from birth to two years of age, so you can be sure that your children are safe and healthy.

**EyeMed Access<sup>TM</sup>:** EyeMed gives you discounts on eye exams, frames and lenses at over 18,500 locations including LensCrafters, Target Optical, and most Sears Optical and Pearle Vision locations.

**Discounted contact lenses:** Through TruVision<sup>TM</sup>, you'll receive up to a 50 percent savings for doctor-prescribed contact lenses and supplies. Also, they are delivered to your home at no extra shipping or handling costs.

**TruVision<sup>TM</sup> LASIK:** TruVision<sup>TM</sup> has contracted with more than 200 board-eligible surgeons who use only FDA-approved lasers for Laser Vision Correction (often called LASIK). Visit TruVision<sup>TM</sup> for pricing (\$749-\$950 per eye based upon the state in which the procedure is performed) and laser location in your area.

**Savings on laser vision correction:** As a Health Net member you have access to significant savings on high-quality laser eye surgery through an arrangement with TLC Laser Eye centers.\*

\*Health Net does not credential the surgeons involved or pay for the procedure.

**Stay fit with WellQuest:** Health Net members are eligible to receive discounts of up to 30% on regular monthly fees at any fitness facility that participates in the extensive WellQuest network.

### Health Net. A Better Decision.

That's why more than 700,000 members in the tri-state area count on us to provide quality health coverage for themselves and their families.

To learn more, or to see if your doctor participates in our extensive network, check out our Web site at [www.healthnet.com](http://www.healthnet.com). We look forward to providing you with superior benefits and welcome your inquiries about our plan.

Health Net  
One Far Mill Crossing  
P.O. Box 904  
Shelton, CT 06484  
1-800-441-5741

In New Jersey, coverage for the HMO is provided by Health Net of New Jersey, Inc. Health Net<sup>®</sup> is a registered service mark of Health Net, Inc. All rights reserved.

# NJ PLUS

**NJ PLUS** is a point-of-service (POS) plan administered by Horizon Blue Cross Blue Shield of New Jersey. NJ PLUS provides you the best of both worlds: in-network care similar to an HMO plan and out-of-network care similar to a traditional plan. Members that wish to use

the in-network level of coverage may select from a vast network of health care professionals and hospitals in the following service areas: New Jersey and Florida, along with several counties in Pennsylvania, Delaware, and New York. Members who wish to use the out-of-network level of coverage, have the freedom to access any eligible health care professional or hospital of their choice in an unrestricted service area. All health care professionals participating in the NJ PLUS network are carefully selected and screened and must meet rigorous professional standards. Periodically, we review the credentials of participating health care professionals and profile their performance to ensure that members receive the best medical care available.

## ***In-Network Coverage***

Upon enrolling, you are encouraged to select a Primary Care Physician (PCP) for yourself and eligible family members. PCPs can be located in any part of the service area and can be different for each family member. You may change your PCP simply by calling Member Services. Your PCP will provide routine care, including annual physical examinations, well-child care and immunizations with an applicable copayment per visit. If you need to see a specialist, your PCP will issue a referral to a participating health care professional with an applicable copayment per visit. Your PCP will also coordinate your hospital care through the NJ PLUS hospital network and you will receive 100 percent coverage.

Female members have direct access to participating Obstetricians/Gynecologists (OB/Gyns) without PCP referral. This includes an annual well-woman exam and other OB/Gyn related services. An applicable copayment applies per visit, but is waived for prenatal and postnatal maternity care visits after the initial visit.

All members have direct access to a participating optometrist or ophthalmologist for an annual vision examination with an applicable copayment. Additional visits require a PCP referral and an applicable copayment.

## ***Out-of-Network Coverage***

When you use out-of-network benefits you incur an annual deductible and coinsurance requirement of 30 percent of reasonable and customary charges. In addition, each out-of-network hospital admission requires a \$200 deductible.

Preventive care or well care — except immunizations for children under 12 months, mammographies, and Pap tests — is not covered at the out-of-network level.

## ***Emergency Care***

If you experience a medical emergency, please go to the nearest emergency facility immediately regardless of network status. You must contact your PCP and/or NJ PLUS within 48 hours. A \$25 copayment applies if you are treated and released but is waived if you are admitted to the hospital. If you do not contact us, coverage will be at 70 percent after an annual deductible. Please note all NJ PLUS PCPs have 24-hour back up coverage in the event he/she is unavailable.

## ***Prescription Drug Coverage***

### ***Active Local Employees - Without a separate Prescription Drug Plan***

If you are an active employee and your employer does not offer a separate prescription drug plan, NJ PLUS provides a discounted prescription drug reimbursement plan. When you present your discount card to the pharmacist you are charged a reduced fee for your medication and your claim is electronically submitted to the carrier for payment. NJ PLUS will reimburse 90 percent of the cost of prescriptions that are written by your network health care professional and 70 percent of the cost of prescriptions, less deductibles, written by your out-of-network health care professional. A mail order service is also available (see page 29).

## **Prescription Drug Coverage - Retirees**

### **Retail Pharmacy - up to a 90-day supply**

		<b>Preferred</b>	<b>All Other</b>
<b>Supply</b>	<b>Generic</b>	<b>Brand</b>	<b>Brands</b>
01-30 days	\$8	\$17	\$34
31-60 days	\$16	\$34	\$68
61-90 days	\$24	\$51	\$102

### **Mail Order - 90-day supply copayment amounts**

	<b>Preferred</b>	<b>All Other</b>
<b>Generic</b>	<b>Brand</b>	<b>Brands</b>
\$8	\$25	\$42

Effective January 1, 2007 there is a \$1,082 annual maximum in prescription drug copayments per person. Once a person has paid \$1,082 in copayments in a calendar year, that person is no longer required to pay any drug copayments for the remainder of that year. Prescription drug copayments are not eligible for reimbursement and do not apply to the NJ PLUS (out-of-network) deductible.

### **Horizon Health and Wellness**

**Education Programs** - NJ PLUS provides disease management education programs for the following: Asthma, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Chronic Heart Failure, Chronic Kidney Disease, Diabetes, Hepatitis C, Multiple Sclerosis, and Obesity. Call 1-888-345-1150 for more details or go to: [www.horizonblue.com/hwp](http://www.horizonblue.com/hwp)

**Precious Additions**<sup>®</sup> - an education and information program for new and expectant parents. Call 1-800-417-SHBP.

**My Health Manager** - Take control of your health with this personalized guide to help you

make smart healthy decisions. for more information go to: [www.horizonblue.com/mhm](http://www.horizonblue.com/mhm)

### **Horizon Wellness Discount Programs**

Horizon BCBSNJ offers various health and wellness discount and education programs. These programs include but are not limited to the following:

**Weight Watchers**<sup>™</sup> - discounts include tools and support to reach your goals. Call 1-800-651-6000 for details.

**Health Club Memberships** - for discounts at New York Sports Clubs call 1-800-301-1231. For discounts through WellQuest Fitness Network call 1-800-595-8448.

**SmartEyes**<sup>SM</sup> - discounts on eyeglasses, accessories, and examinations through Cole Managed Vision located at Sears, JCPenny, Target, and Pearle Vision Centers. Call 1-800-424-1155 (use plan number 46492).

**Complete Advantage** - discounts on laser vision correction services through Davis Vision. Call 1-877-518-8748 (use access code 2410).

**HearUSA** - discounts on hearing aids. Call 1-800-999-1458.

**Horizon Alternative Therapies** - discounts on services such as yoga, massage therapy, and acupuncture. Call 1-877-335-2746.

**Healthyroads** - discounts on vitamins, supplements, smoking cessation programs, and other health-related products. Call 1-877-335-2746.

To take advantage of these programs, present your NJ PLUS ID card at a participating business or mention that you are a Horizon BCBSNJ member when calling. For a complete listing and description of available discount programs, please go to: [www.horizonblue.com/discounts](http://www.horizonblue.com/discounts)

#### **For Additional Information**

If you have questions, please call NJ PLUS Member Services at 1-800-414-SHBP (7427) during our service hours of Monday through Friday, 8:00 a.m. to 6:00 p.m. You may also access our interactive Web site at: [www.horizonblue.com/shbp](http://www.horizonblue.com/shbp) or write to us at:

**Horizon Blue Cross Blue Shield of New Jersey**  
**NJ PLUS**  
**P.O. Box 820**  
**Newark, New Jersey 07101-0820**



**OXFORD**  
HEALTH PLANS®

A United Healthcare Company

## ACCESS TO QUALITY NETWORK AND PROGRAMS

- **Access to a Quality Network** - Helping Members get to a healthier place starts with our physician network. Oxford Members have access to a large tri-state area network.
- **Choice of over 70,000<sup>1</sup> credentialed physicians in the tri-state area (New Jersey, New York and Connecticut)** - The large majority are board-certified or board-eligible.
- **Complementary and Alternative Medicine Program** - Members have access to the area's first credentialed network of Complementary and Alternative medical providers, including chiropractors, acupuncturists, massage therapists, yoga instructors, and nutritionists<sup>2</sup>.
- **Wide Access to Pharmacies** - Members with pharmacy benefits can fill their prescriptions via mail order and a local network of more than 7,000<sup>3</sup> retail pharmacies in the tri-state area, including major chains.
- **Access to Most of the Area's Finest Hospitals** - Our network includes St. Barnabas Healthcare System and Robert Wood Johnson University Hospital.
- **OB/GYN Access Without a Referral** - Women can visit an OB/GYN without a referral.

## MAKING WELLNESS A PART OF YOUR LIFE

- **No Copayments for Selected In-Network Care** - Annual physicals, one well-woman exam every six months, routine pediatric care, and immunizations.
- **Prescription Drug Coverage** - Some plans include prescription drug coverage, including those that are available for retirees. A \$5 generic copayment, a \$10 preferred brand copayment, and a \$20 non-preferred brand copayment per 30-day supply apply at a retail pharmacy. A prescription mail-order program for certain maintenance medications is also available for a 90-day supply with a \$5 generic copayment, a \$15 preferred brand copayment, and a \$25 non-preferred brand copayment.
- **Disease Management Programs** - Proactive efforts to help Members manage chronic conditions, such as asthma or diabetes, through educational materials.
- **Active Partner® Program** - Personal reminders that encourage Members to receive important preventive care, including mammograms and flu shots.
- **Oxford Healthy Mother, Healthy Baby®** - A program designed to help maintain the health of pregnant mothers and newborns.

- **Healthy Bonus**<sup>4</sup> - Discounts and special offers on programs, such as Weight Watchers®, fitness clubs, and Modell's Sporting Goods® stores.
- **Gym Reimbursement** - To keep Members motivated to achieve their fitness goals, the plan provides limited reimbursement towards fitness center membership fees. Members who complete a minimum of 50 visits per six-month period receive up to \$100 reimbursement, and their covered spouses receive up to \$50 per six-month period.<sup>5</sup>

## INFORMATION WHEN, WHERE, AND HOW YOU WANT IT

- **Oxford On-Call**<sup>®</sup> - A 24-hour healthcare guidance line staffed by registered nurses to help guide Members to an appropriate source of care.
- **www.oxfordhealth.com** - Members can search for providers, check benefits or referrals, order ID cards, request materials, or access wellness resources.
- **Commitment to serve** - Our Customer Service Associates work to resolve Member issues in a thorough, courteous, and timely manner.

**If you are not an Oxford Member and would like to learn more,  
call: 1-800-760-4566 or visit [www.oxfordhealth.com](http://www.oxfordhealth.com)**



**OXFORD**  
HEALTH PLANS<sup>®</sup>

A United Healthcare Company

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<sup>1</sup>As of 6/30/06. This data represents all Freedom Network participating providers except ancillary providers. Dental and alternative medicine providers are included (6% of the total without chiropractors who are considered specialists). Providers who are multiply boarded are counted multiple times.

<sup>2</sup>Provider type varies by region.

<sup>3</sup>Medco network data as of 7/14/2006.

<sup>4</sup>Offers are valid through December 31, 2006. These discounts are offered in addition to, and separate from, your benefit coverage through your employer and administered by Oxford Health Plans. These arrangements have been made for the benefit of Members, and do not represent an endorsement or guarantee on the part of Oxford. Discounts may change from time to time without notice and are applicable to the items referenced only. Oxford cannot assume any responsibility for the products or services provided by vendors or the failure of vendors referenced to make available discounts negotiated with Oxford; however, any failure to receive discounts should be reported to Oxford Customer Service by calling the number on your Member ID card.

<sup>5</sup>Oxford Members and their spouses must be covered Oxford Members for the entire six-month period to receive reimbursement.



Horizon Blue Cross Blue Shield of New Jersey

*Making Healthcare Work™*

## Traditional Plan

cover preventive treatment (with the exception of mammographies and Pap tests) such as immunizations, physical examinations, or well-care physician visits. The Traditional Plan has three components: basic benefits (hospitalization), extended basic benefits (medical-surgical/professional) and major medical benefits.

### **Basic Benefits**

Basic benefits include inpatient covered services at an approved acute care hospital, skilled nursing facility, or detoxification facility; and outpatient covered services billed by an approved facility or home health care agency, birthing center, and same-day surgical center.

### **Extended Basic Benefits**

Extended basic benefits, also known as medical-surgical or professional benefits are paid according to a fee schedule and cover certain charges billed by an eligible health care professional for services such as surgery, anesthesia, X-rays, laboratory tests, and inpatient medical care.

### **Major Medical Benefits**

Major medical benefits provide coverage for eligible services such as physician charges, medical services, and other supplies not completely paid under the basic and extended basic portions of the Traditional Plan. Under major medical, there is an annual deductible per employee and a combined annual deductible per family. Once your deductible has been met, the plan will pay 80 percent of the reasonable and customary fee. After an individual has \$2,000 in eligible major medical charges during a calendar year, the plan will pay 100 percent of the reasonable and customary fees for the remainder of the calendar year. You are responsible for a 20 percent coinsurance (or \$400 out-of-pocket per individual), plus any ineligible costs or charges that are denied as being above the reasonable and customary fee for a service within the area where it was provided. The lifetime benefit maximum,

**The Traditional Plan** is an indemnity plan administered by Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ). Under the plan, you have freedom of choice to seek medical treatment from any properly licensed health care professional or hospital, as defined by the plan, anywhere in the world. However, the plan only provides reimbursement of expenses for the diagnosis and treatment of illness and injury. The plan does not

under the major medical portion of the Traditional Plan only, is \$1,000,000 per individual. However, there is a limited automatic restoration feature whereby, at the start of each calendar year, any previously used amount of the lifetime maximum will be restored up to the lesser of \$2,000 or the amount needed to completely restore the maximum.

### **Participating Traditional Plan Health Care Professionals**

Under the Traditional Plan, over 31,000 health care professionals in NJ, NY, and PA participating with Horizon BCBSNJ, have agreed to accept the Horizon BCBSNJ allowance, and are precluded from billing above that amount. In addition, these health care professionals have agreed to accept no payment at the time of service and to submit claims on your behalf to Horizon BCBSNJ. You are only responsible for your annual deductible and 20 percent coinsurance based upon the discounted fee for eligible services, thereby reducing your out-of-pocket cost. There are similar arrangements with health care professionals throughout the country with other Blue Cross and Blue Shield plans.

### **Prescription Drug Coverage**

#### **Active Local Employees - Without a Separate Prescription Plan**

If you are an active employee and your employer does not offer a prescription drug plan, the Traditional Plan provides a discounted prescription drug reimbursement plan through major medical benefits. When you present your discount card to the pharmacist you are charged a

reduced fee for your medication and your claim is electronically submitted to the carrier for payment. After deductibles are met the Traditional Plan will reimburse 80 percent of the prescription cost. A mail order service is also available (see page 29).

**Prescription Drug Coverage - Retirees  
Retail Pharmacy - up to a 90-day supply**

Supply	Generic	Preferred Brand	All Other Brands
01-30 days	\$8	\$17	\$34
31-60 days	\$16	\$34	\$68
61-90 days	\$24	\$51	\$102

**Mail Order - 90-day supply copayment amounts**

Generic	Preferred Brand	All Other Brands
\$8	\$25	\$42

Effective January 1, 2007 there is a \$1,082 annual maximum in prescription drug copayments per person. Once a person has paid \$1,082 in copayments in a calendar year, that person is no longer required to pay any drug copayments for the remainder of that year. Prescription drug copayments are not eligible for reimbursement and do not apply to the Traditional Plan deductible or coinsurance.

**Horizon Health and Wellness**

**My Health Manager** - Take control of your health with this personalized guide to help you make smart healthy decisions. for more information go to: [www.horizonblue.com/mhm](http://www.horizonblue.com/mhm)

**Horizon Wellness Discount Programs**

Horizon BCBSNJ has established relationships with several businesses to provide various discount programs. These programs include but are not limited to the following:

**Weight Watchers™** - discounts include tools and support to reach your goals. Call 1-800-651-6000 for more details.

**Health Club Memberships** - for discounts at New York Sports Clubs call 1-800-301-1231. For discounts through WellQuest Fitness Network call 1-800-595-8448.

**SmartEyes<sup>SM</sup>** - discounts on eyeglasses, accessories, and examinations through Cole Managed Vision located at Sears, JCPenny, Target, and Pearle Vision Centers. Call 1-800-424-1155 (use plan number 46492).

**Complete Advantage** - discounts on laser vision correction services through Davis Vision. Call 1-877-518-8748 (use access code 2410).

**HearUSA** - discounts on hearing aids. Call 1-800-999-1458.

**Horizon Alternative Therapies** - discounts on services such as yoga, massage therapy, and acupuncture. Call 1-877-335-2746.

**Healthyroads** - discounts on vitamins, supplements, smoking cessation programs, and other health-related products. Call 1-877-335-2746.

To take advantage of these programs, present your Traditional Plan ID card at a participating business or mention that you are a Horizon BCBSNJ member when calling. For a complete listing and description of available discount programs go to: [www.horizonblue.com/discounts](http://www.horizonblue.com/discounts)

**For Additional Information**

If you have questions, please call Traditional Plan Member Service at 1-800-414-SHBP (7427) during our service hours of Monday through Friday, 8:00 a.m. to 6:00 p.m. You may also access our interactive Web site at: [www.horizonblue.com/shbp](http://www.horizonblue.com/shbp) or write to us at:

**Horizon Blue Cross Blue Shield of New Jersey  
Traditional Plan  
P.O. Box 1609  
Newark, New Jersey 07101-1609**

## PRESCRIPTION DRUG BENEFITS

### EMPLOYEE PRESCRIPTION DRUG PLAN

The Employee Prescription Drug Plan is offered to active State employees and their eligible dependents as a separate drug plan. Local employers may also elect to provide the SHBP Employee Prescription Drug Plan to their employees as a separate prescription drug benefit.

The Employee Prescription Drug Plan is currently administered by Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) through Caremark.

#### Plan Benefits

Employee Prescription Drug Plan benefits are available through a participating **retail pharmacy** or through the Caremark **mail order** and **specialty pharmacy services**.

- **Retail pharmacy** services require a \$3 copayment for **generic** drugs and a \$10 copayment for **brand name** drugs for each 30-day supply. Employee Prescription Drug Plan participants may obtain up to a 90-day supply of prescription drugs at participating retail pharmacies. You are required to pay two copayments for a 31 to 60-day supply or three copayments for a 61 to 90-day supply.
- **Mail order** participants can receive up to a 90-day supply of prescription drugs for one copayment of \$5 for **generic** drugs and \$15 for **brand name** drugs.
- **Specialty Pharmacy Services** are provided through Caremark Specialty Pharmacy which is the exclusive provider for specialty pharmaceuticals for the SHBP's prescription drug plans. Specialty pharmaceuticals are a class of medications that are typically produced through biotechnology, administered by injection, and/or require special patient monitoring and handling. If your doctor has prescribed a specialty pharmaceutical, you will not be able to fill the prescription at a retail pharmacy. If you try to fill a specialty prescription at a retail pharmacy, the pharmacy representative will advise you to contact CaremarkConnect at 1-800-237-2767. When calling, identify yourself as a State Health Benefits Program member. Caremark will contact your doctor and take care of the appropriate paperwork. Your medication will be shipped directly to your home, office, or doctor's office.

For more information about specific Employee Prescription Drug Plan benefits, copayment amounts, and claim procedures, see the *Employee Prescription Drug Plan Member Handbook* which is available from your employer, from the Division of Pensions and Benefits, or on the SHBP home page at: [www.state.nj.us/treasury/pensions/shbp.htm](http://www.state.nj.us/treasury/pensions/shbp.htm)

## PRESCRIPTION DRUG BENEFITS PROVIDED THROUGH SHBP HEALTH PLANS

The State Health Benefits Commission requires that all participating employees and retirees have access to prescription drug coverage.

- **If you are employed by a county, municipality, board of education, or other local public employer which does not provide a separate prescription drug plan**, your SHBP health plan will include prescription drug benefits.
- **If you are eligible for prescription drug coverage through a separate drug plan provided by your employer**, your SHBP medical plan will not include prescription drug coverage and any prescription drug copayments from other group plans will not be reimbursed through the Traditional Plan, NJ PLUS, or any SHBP HMO.

### Employee Prescription Drug Reimbursement Plan for Traditional Plan and NJ PLUS

Active employees whose employer does not offer a separate prescription drug plan have prescription drug coverage through the Employee Prescription Drug Reimbursement Plan of the Traditional Plan and NJ PLUS. By presenting a discount prescription drug card to the pharmacist, members are charged a reduced fee and the claim is electronically submitted to the plan for consideration.

A mail order service is also available through the Employee Prescription Drug Reimbursement Plan of the Traditional Plan and NJ PLUS for active employees (and COBRA participants) who do not have a separate prescription drug plan through their employer. The mail order service is administered by Horizon Blue Cross Blue Shield of New Jersey through Caremark. Members may also obtain prescriptions online from Caremark.

Specialty pharmacy services also apply — for details see “Specialty Pharmacy Services” on page 28.

For more information about Employee Prescription Drug Reimbursement Plan benefits, coin-surance amounts, and claim procedures, see the plan description pages in this booklet or the *Traditional Plan* or *NJ PLUS Member Handbooks* which are available from your employer, from the Division of Pensions and Benefits, or on the SHBP home page at: [www.state.nj.us/treasury/pensions/shbp.htm](http://www.state.nj.us/treasury/pensions/shbp.htm).

### Participating SHBP HMOs

The SHBP HMOs provide a prescription drug card benefit for those employees whose employer does not offer a separate prescription drug plan. The plan features a three-tiered design with copayments for up to a 30-day supply of \$5 for **generic** drugs (Tier I), \$10 for **preferred brand name** drugs (Tier II), and \$20 for **all other brand name** drugs (Tier III) when purchased at a participating retail pharmacy and prescribed by your Primary Care Physician (PCP) or a provider to whom your PCP has referred you. Certain prescription drugs may require precertification prior to purchase.

The purchase at a pharmacy of up to a 90-day supply of medication may also be available by paying the applicable copayments (60-day supply — two copayments, 90-day supply — three copayments).

A mail order program is also available. Mail order copayments for up to a 90-day supply are \$5 for **generic** drugs, \$15 for **preferred brand name** drugs, and \$25 for **all other brand name** drugs.

For more information about HMO plan prescription drug benefits, copayment amounts, and claim procedures, see the plan description pages in this booklet or the individual HMO plan member handbooks. Contact information for the SHBP-participating HMOs is available on the plan description pages.

## RETIREE PRESCRIPTION DRUG COVERAGE

### Medicare Part D

Most Medicare eligible retirees and/or their Medicare eligible dependents need not enroll in Medicare Part D prescription drug coverage. Some SHBP 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 Medicare Part D, your SHBP retired group prescription drug benefits will be terminated for both you and your dependents.

### Traditional Plan and NJ PLUS

Retirees enrolled in the Traditional Plan or NJ PLUS have access to a separate Retiree Prescription Drug Plan that includes retail pharmacy, mail order, and specialty pharmacy services. The plan is administered by Horizon Blue Cross Blue Shield of New Jersey and features a three-tiered copayment design.

Effective January 1, 2007, copayment amounts for a 30-day supply are set at \$8 for **generic** drugs (Tier I), \$17 for **preferred brand name** drugs (Tier II), and \$34 for **all other brand name** drugs (Tier III) when purchased at a participating retail pharmacy. You may purchase up to a 90-day supply of medication at a pharmacy when prescribed by your provider, by paying the applicable copayments (31- to 60-day supply — two copayments, 61- to 90-day supply — three copayments).

Mail order copayments for up to a 90-day supply are \$8 for **generic** drugs, \$25 for **preferred brand name** drugs, and \$42 for **all other brand name** drugs.

Specialty pharmacy services also apply — for details see “Specialty Pharmacy Services” on page 28.

Effective January 1, 2007, the annual maximum out-of-pocket for prescription drug copayments is \$1,082 per person. Once a person has paid \$1,082 in copayments, that person is no longer required to pay any prescription drug copayments for the remainder of that calendar year.

For more information about Retiree Prescription Drug Plan benefits and claim procedures, see the plan description pages in this booklet or the *Traditional Plan or NJ PLUS Member Handbooks* which are available from the Division of Pensions and Benefits or on the SHBP home page at: [www.state.nj.us/treasury/pensions/shbp.htm](http://www.state.nj.us/treasury/pensions/shbp.htm).

### Participating SHBP HMOs

The SHBP **HMOs** provide retirees with prescription drug benefits. The plan features a three-tiered design with copayments for up to a 30-day supply of \$5 for **generic** drugs (Tier I), \$10

for **preferred brand name** drugs (Tier II), and \$20 for **all other brand name** drugs (Tier III) when purchased at a participating retail pharmacy and prescribed by your Primary Care Physician (PCP) or a provider to whom your PCP has referred you. Certain prescription drugs may require precertification prior to purchase.

The purchase of up to a 90-day supply of medication at a pharmacy may also be available by paying the applicable copayments (31- to 60-day supply — two copayments, 61- to 90-day supply — three copayments).

A mail order program is also available. Mail order copayments for up to a 90-day supply are \$5 for **generic** drugs, \$15 for **preferred brand name** drugs, and \$25 for **all other brand name** drugs.

For more information about HMO plan prescription drug benefits, copayment amounts, and claim procedures, see the plan description pages in this booklet or the individual HMO plan member handbooks. Contact information for the SHBP-participating HMOs is available on the plan description pages.

## **SHBP DENTAL PLANS**

Dental coverage is available through the SHBP Dental Plans, which consists of the Employee Dental Plans and the Retiree Dental Expense Plan.

### **EMPLOYEE DENTAL PLANS**

The SHBP 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 SHBP offers enrollment into one of several dental plans. These plans fall under one of two basic types: the indemnity style Dental Expense Plan, and one of several Dental Plan Organizations (DPOs).

For more information about the SHBP Employee Dental Plans, copayment amounts, and specific benefits, see the SHBP *Employee Dental Plans Member Handbook* or Fact Sheet #37, *SHBP Employee Dental Plans*, which is available from your employer, by contacting the Division of Pensions and Benefits, or at the Division's Web site at: [www.state.nj.us/treasury/pensions](http://www.state.nj.us/treasury/pensions).

### **RETIREE DENTAL EXPENSE PLAN**

The Retiree Dental Expense Plan, administered for the SHBP by Aetna Dental, is available to State and local retirees eligible to enroll in the Retired Group of the SHBP. All State and most other retirees who enroll in the Retiree Dental Expense Plan will be responsible for paying the full cost of their coverage.

For more information about the Retiree Dental Expense Plan, see the SHBP *Retiree Dental Expense Plan Member Handbook* or Fact Sheet #73, *Retiree Dental Expense Plan*, which is available from your employer, by contacting the Division of Pensions and Benefits, or at the Division's Web site at: [www.state.nj.us/treasury/pensions](http://www.state.nj.us/treasury/pensions).

## 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 hrs. 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 . . . . .	(856) 234-5652 (908) 231-1077 (609) 633-3718 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 available to State employees under Section 125 of the federal Internal Revenue Service Code. This voluntary program allows eligible employees to set aside before-tax dollars to pay for certain medical, dental, and dependent care expenses, thereby avoiding federal taxes and saving money. Tax\$ave consists of three components: The **Premium Option Plan**, the **Unreimbursed Medical Spending Account Plan**, and the **Dependent Care Spending Account Plan**. See the "Tax\$ave" section on page 62 of this booklet for a description of the Tax\$ave plans and important information about how enrollment in Tax\$ave could affect your SHBP coverage.

**Note:** The *Tax\$ave* program is not available to local employees. Contact your employer to find out if you are eligible to pay premiums on a pre-tax basis through an IRC Section 125 Program offered by your employer.

# ENROLLING IN THE STATE HEALTH BENEFITS PROGRAM

## ACTIVE EMPLOYEE ENROLLMENT

You are not covered until you enroll in the SHBP. You must fill out a *NJ State Health Benefits Program Application* and provide all the information requested. 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 34 for exceptions).

### Open Enrollment

The SHBP holds an annual Open Enrollment period for all eligible State employees and local participating employees. Specific dates for the Open Enrollment period are announced in advance by the SHBP. 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 by the SHBP for which you are eligible, if you have not previously enrolled;
- change to another eligible SHBP 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 5); and
- delete dependents (this can also be done at any time during the year).

### Dual HMO Enrollment is Prohibited

State statute specifically prohibits two members who are married to each other, or eligible same-sex domestic partners, who are **both** enrolled in the SHBP from enrolling each other under any **two** of the SHBP’s HMO plans. One member may belong to a SHBP HMO as an employee or as a dependent but not as both.

For example, if two SHBP members are married to each other, each may elect to enroll for single coverage under any of the HMO plans, or one member can enroll the other as a dependent under a SHBP HMO if the other person has the Traditional Plan or NJ PLUS coverage.

Furthermore, two SHBP members cannot both cover the same children as dependents under any two SHBP HMO plans.

In cases of divorce or single parent coverage of dependents, there is **no coordination of benefits** under two HMO plans.

## Waiver of Coverage

A municipality, municipal authority, or county college participating in the SHBP may allow an employee covered as a dependent by a spouse's employer to waive SHBP health benefits coverage and be reimbursed up to 50 percent of the amount saved by the employer. Coverage may be resumed if the spouse's dependent coverage is no longer in effect. The decision of a municipality, municipal authority, or county college 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 *NJ State Health Benefits Program Application* within 60 days of the event.**

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 dependent children. **A photocopy of the marriage certificate must accompany the application.**
- You enter into a same-sex domestic partnership and want to enroll your eligible same-sex domestic partner and newly eligible dependent children. **A photocopy of the *Certificate of Domestic Partnership* must accompany the application.** (May not apply to all employees, see page 4 for additional information about same-sex domestic partners.)
- You need to enroll a child. **A photocopy of legal documentation (adoption or guardianship papers, etc.) must accompany the application.**
- Your child, under the age of 23, has divorced and moves back into your household, and is dependent upon you for support and maintenance. **A photocopy of the child's divorce decree must accompany the application.**
- You have a change in family status involving the loss of eligibility of a family member (divorce; dissolution of a same-sex domestic partnership; death; child marries, enters into a domestic partnership, or no longer lives with you).
- Your spouse'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's and/or dependent's *Certificate of Continued Coverage* 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 move out of a plan's service area. You can change plans immediately; however, if you do not change within 30 days of the move, you must wait until the next Annual Open Enrollment period.

- 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 SHBP health benefits coverage begins, provided you submit a completed *NJ State Health Benefits Program Application*.** 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, 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 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" below.)

Coverage changes involving the addition of dependents are effective retroactive to the date of the event (marriage, birth, adoption, etc.) providing the application is filed within 60 days of the event. Deletion of dependents is effective on a timely or prospective basis, depending upon receipt of the application by the Health Benefits Bureau. Dependent children are automatically terminated as of the end of the year they attain age 23 and do not require the completion of an application to decrease coverage.

### **Transfer of Employment**

If you transfer from one SHBP-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 (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 *NJ State 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 *NJ State 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**

State and local employees participating in the SHBP are entitled to have their 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 SHBP coverage will continue at the employer's expense. You must remit to your employer, in advance, that portion of the premiums you normally pay, if any.

The Department of Personnel Merit System Board issued a "rule relaxation" extending through June 30, 2007. During this period, a State employee can take unlimited furlough, if approved by their employer, without loss of employer paid health benefits.

Without further extension by the Department of Personnel Merit System Board, as of July 1, 2007, the "rule relaxation" will cease and health benefits will only be covered for up to 30 days

of furlough. Extensions beyond the normal 30 days allowed will be treated as an exceptional case. You will have to pay for the full cost of coverage for your extended furlough in biweekly increments or drop your coverage for the entire benefit period in which you take a 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 45) 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 *NJ State Health Benefits Program Application*. 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 *NJ State 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 *NJ State 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 62);

- 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 SHBP to change to another plan;
- your employer ceases to participate in the SHBP; or
- the SHBP is discontinued.

Coverage for your dependents (including over age children eligible under Chapter 375, see page 5) will end if:

- your coverage ceases for any of the reasons listed above;
- you die (**dependent coverage terminates the 1<sup>st</sup> day of the biweekly coverage period following the date of death of State employees paid through the State’s Centralized Payroll Unit, or the 1<sup>st</sup> 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 same-sex domestic partnership; children marry, enter into a domestic partnership, move out of the household, or is over age 23 — age 30 if covered under Chapter 375 — except where the over age child qualifies for coverage due to disability — see page 5);
- 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 subscriber.

### **Medicare Parts A and B**

In general, it is not necessary for a Medicare-eligible employee, spouse, eligible same-sex domestic 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 40.

### **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 SHBP 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 Medicare Part D, your SHBP prescription drug benefits will be terminated for both you and your dependents.

## RETIREE ENROLLMENT

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

### Dual HMO Enrollment is Prohibited

State statute specifically prohibits two members who are married to each other, or eligible same-sex domestic partners, who are **both** enrolled in the SHBP from enrolling under any **two** of the SHBP's HMO plans. One member may belong to a SHBP HMO as an employee/retiree or as a dependent but not as both.

For example, if two SHBP members are married to each other or same-sex domestic partners, each may elect to enroll for single coverage under any of the HMO plans, or one member can enroll the other as a dependent under a SHBP HMO if the other person has the Traditional Plan or NJ PLUS coverage.

Furthermore, two SHBP members cannot both cover the same children as dependents under any two SHBP HMO plans.

In cases of divorce or single parent coverage of dependents, there is **no coordination of benefits** under two HMO plans.

### Closure of Traditional Plan to Fraternal Order of Police and State Police Units

Retirees, **who retire after July 1, 2005**, from State law enforcement bargaining units (most Fraternal Order of Police units, see note, and all State Police units including non-aligned officers) cannot participate in the SHBP Traditional Plan regardless of their years of service credit.

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

### Waiver of Coverage

As an eligible retiree:

- You may waive coverage with the Retired Group of the SHBP and retain your right to enroll at a later date if you are covered as an employee or as a dependent of your spouse 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 of the SHBP when your coverage terminates with the other employer, provided that you notify the SHBP within 60 days of the loss of coverage, submit a completed *SHBP Retired Status Application*, and provide proof that the previous coverage was in effect.
- If you are otherwise eligible for enrollment in the SHBP 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 of the SHBP when your coverage terminates with the other employer, provided that you notify the SHBP within 60 days of the loss of coverage and request enrollment materials.

## MEDICARE COVERAGE IS REQUIRED IF ELIGIBLE

### Medicare Parts A and B

**IMPORTANT: A Retired Group member and/or dependent spouse, 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 SHBP Retired Group coverage.**

You will be required to submit documentation of enrollment in Medicare Parts A and B when you become eligible for that coverage. Acceptable documentation includes a photocopy of your Medicare card showing both your Part A and B enrollment or a letter from Medicare indicating the effective dates of both your Parts A and 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 Parts A and B, you and/or your dependents will be terminated from the SHBP. Upon submission of proof of full Medicare coverage, your coverage will be reinstated by the SHBP on a prospective basis.

**IMPORTANT: If a provider does not participate with Medicare, no benefits are payable under the SHBP for the provider's services.**

### Medicare Part D

Most Medicare eligible retirees and/or their Medicare eligible dependents need not enroll in Medicare Part D prescription drug coverage. Some SHBP 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 Medicare Part D, your SHBP retired group prescription drug benefits will be terminated for both you and your dependents.

### Medicare Eligibility

A Member May be Eligible for Medicare for the Following Reasons:

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

This applies to a member who is the retiree or covered spouse/same-sex domestic partner and is at least 65 years of age.

A member 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.**

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

This applies to a member who is under age 65.

A member 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.**

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

A member usually becomes eligible for Medicare at age 65 or upon receiving Social Security Disability benefits for two years. A member 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***

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***

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 after 1996, the coordination of benefits period is 30 months.

***When Medicare is primary***

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

***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**

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

### ***If You are Using 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 SHBP 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 SHBP plan.

### ***If You are Using 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, 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.

If the application to add a spouse, eligible same-sex domestic partner, or dependent is not received within 60 days of the status change, 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 SHBP 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 should complete a *SHBP Retired Status Application* which is available on our Web site: [www.state.nj.us/treasury/pensions/shbp.htm](http://www.state.nj.us/treasury/pensions/shbp.htm) or by contacting the Office of Client Services at the Division of Pensions and Benefits (see page 65).

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. A retiree may also change plans if the retiree is covered under NJ PLUS or an HMO and moves into or out of the plan's service area.

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

- You marry and want to enroll your spouse. A photocopy of the marriage certificate is required for enrollment.
- You enter into a same-sex domestic partnership and want to enroll your eligible same-sex domestic partner. A photocopy of the *Certificate of Domestic Partnership* is required for enrollment. (May not apply to all retirees, see page 4 for additional information about same-sex domestic partners.)
- You need to enroll a new child.
- You have a change in family status involving the loss of eligibility of a family member (separation; divorce; dissolution of a same-sex domestic partnership; death; child marries, no longer lives at home, or turns age 23).
- You wish to change your medical plan. A Retired Group member can switch medical plans once in any 12-month period or when rates change.
- You move out of the plan's service area. The 12-month change rule mentioned above is waived in these cases.
- Your spouse'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 *SHBP Retired Status Application* to remove from your coverage a deceased or ineligible spouse for whom you receive a Medicare Part B reimbursement will result in the need for you to reimburse all incorrectly paid amounts.

### **Effective Dates**

The effective date of any change in which a dependent is added to coverage because of **marriage, birth, or adoption** is retroactive to the date the event occurred if the *Retired Status Application* is filed within 60 days of the event (marriage, birth, adoption, etc.) with the SHBP. If the *Retired Status Application* is not received within 60 days of the event by the SHBP, the effective date will be the first of the month following a full two-month waiting period from the date of receipt of the application.

You are responsible for notifying the Health Benefits Bureau of a coverage change due to **death or divorce**. The effective date is the first day of the month following the date of death or divorce. 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 *SHBP Retired Status Application*;
- your retirement is canceled;
- your pension allowance is suspended;
- you do not pay your required premiums;
- your plan discontinues services in your area and you do not submit an application to the SHBP to change to another plan;
- you or your spouse do not provide proof of enrollment in Medicare Parts A and B when eligible for Medicare coverage;
- your former employer withdraws from the SHBP (this may not apply to certain retirees of education, police, and fire employers);
- your Medicare coverage ends;
- you die (**dependent coverage terminates the 1<sup>st</sup> of the month following the date of death**); or
- the SHBP is discontinued.

### **Survivor Coverage**

If you, the retired member, predecease your covered spouse and/or other covered eligible dependents, your surviving dependents may be eligible for continued coverage in the SHBP. 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 1<sup>st</sup> of the month following the date of your death**.

A surviving spouse may request coverage for all of the eligible dependents that had been listed on the retiree's coverage but, except for a newborn baby, cannot list as a dependent anyone who had not been covered under the benefits of the deceased subscriber.

## 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, the SHBP allows certain members who lose their retired group coverage to continue coverage under COBRA. COBRA coverage is available for limited time periods (see "Duration of COBRA Coverage" on page 46), 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, 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 medical coverage and, if offered by your employer, State prescription drug coverage during the SHBP 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 SHBP 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 the State Health Benefits Commission makes changes 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 same-sex domestic partnership (makes spouse or same-sex domestic partner ineligible for further dependent coverage).
- Loss of a dependent child's eligibility through independence (moving out of household), the attainment of age 23, marriage, or domestic partnership.

- 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 5).

### **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 same-sex domestic partnership**, or he or she becomes ineligible for continued group coverage because of **marriage, entering into a domestic partnership, attaining age 23, or moving out of the household**, 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 or eligible same-sex domestic 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 SHBP 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 same-sex domestic partnership, or death has occurred or that your child has married, entered into a domestic partnership, moved out of your household, or reached age 23 — notification must be given within 60 days of the date the event occurred;
- file a *COBRA Application* within 60 days of the loss of coverage or the date of the COBRA Notice provided by your employer, whichever is later;
- pay the required monthly premiums in a timely manner; 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 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;
- you become eligible for Medicare after you elect COBRA coverage. (This affects health insurance only, not dental, prescription, or vision coverage.)

## **SPECIAL PLAN PROVISIONS UNDER THE SHBP**

### **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 SHBP will provide secondary coverage to Personal Injury Protection (PIP) unless you choose your SHBP 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 health plan, then the SHBP will automatically be primary to your PIP policy. If you elect your SHBP plan as primary, this election may affect each of your family members differently.

When the SHBP is primary to your PIP policy, benefits are paid in accordance with the terms, conditions, and limits set forth by the SHBP health plan you have chosen. For example, if you are enrolled in an HMO you would need referrals from your Primary Care Physician, precertifications, preauthorizations, etc., just as you would for any other treatment to be covered. Your PIP policy would be a secondary payer to whom you would submit any bills unpaid by your SHBP 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 retiree group and Medicare is primary for you and/or your spouse or eligible partner, you do not have the option to select the SHBP as primary to your PIP policy.

If your SHBP 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 plan, after application of any deductibles and coinsurance; or
- the actual benefits that would have been payable had your SHBP 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.** 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 State Health Benefits Program, 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 2007 and is expected to file an exemption for calendar year 2008. As a result, the maximum annual and lifetime dollar limits for mental health benefits under the Traditional Plan and NJ PLUS will not change, with an exception for *biologically-based* mental illness. Maximum annual and lifetime dollar limits for mental health benefits are outlined in the *Traditional Plan* and *NJ PLUS Member Handbooks* and the *SHBP Comparison Summary* chart (see page 66).

All SHBP health plans meet or exceed the federal requirements with the exception of mental health parity for the Traditional Plan and NJ PLUS. Parity requires that the dollar limitations 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 State Health Benefits 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 its members' physical or mental health. See page 58 for the State Health Benefits Program's *Notice of Privacy Practices*.

## **NOTICE OF PROVIDER TERMINATION**

Any person enrolled in a managed care plan (HMO or NJ PLUS) must be provided with 90-day notice if that person's Primary Care Physician (PCP) will be terminated from the provider network. If 90-day notice cannot be provided, the managed care plan must notify the member as soon as possible. The covered person may then choose another PCP or may change coverage to another participating health benefits plan.

## **PURCHASE OF INDIVIDUAL INSURANCE COVERAGE**

Employees, retirees, and their dependents may purchase individual, direct payment coverage from their State Health Benefits Program (SHBP) health plan carrier if their loss of group health coverage is due to any reason other than voluntary termination. Note: failure to pay required premiums is considered voluntary termination.

Before considering a policy, New Jersey residents who are not Medicare eligible, should first investigate coverage available under the provisions of the New Jersey Individual Health Coverage Program. Information about available policies can be obtained from the New Jersey Individual Health Coverage Board at the Department of Banking and Insurance. Carrier and rate information can be obtained by calling 1-800-838-0935 or at [www.njdobi.org](http://www.njdobi.org)

If you are Medicare eligible you may qualify for a Medigap policy. For more information, call the State Health Insurance Assistance Program (SHIP) at 1-800-792-8820.

You will have 31 days from the end of your SHBP coverage to exercise your right to a direct payment policy.

## **MEDICAL PLAN EXTENSION OF BENEFITS**

If you are totally disabled with a condition or illness at the time of your termination from the SHBP 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 SHBP 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 SHBP performs an audit using a random sample of members to determine if dependents are eligible under plan provisions. Proof of dependency such as a marriage certificate or birth certificate is required. Coverage for ineligible dependents will be terminated and repayment of treatment services for ineligible dependents will be pursued. Failure to respond to the audit will result in the termination of coverage for dependents.

## APPENDIX

### CLAIM APPEAL PROCEDURES

You or your authorized representative may appeal and request that your health plan reconsider any claim or any portion(s) of a claim for which you believe benefits have been erroneously denied based on the plan's limitations and/or exclusions. This appeal may be of an administrative or medical nature. Administrative appeals might question eligibility or plan benefit decisions such as whether a particular service is covered or paid appropriately. Medical appeals refer to the determination of medical need, appropriateness of treatment, or experimental and/or investigational procedures.

The following information must be given at the time of each inquiry.

- name(s) and address(es) of patient and employee;
- employee's identification number;
- date(s) of service(s);
- provider's name and identification number;
- the specific remedy being sought; and
- the reason you think the claim should be reconsidered.

If you have any additional information or evidence about the claim that was not given when the claim was first submitted, be sure to include it.

If dissatisfied with a final health plan decision on a medical appeal, only the member or the member's legal representative (this does not include the provider of service) may appeal, in writing, to the State Health Benefits 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 consideration must contain the reason for the disagreement along with copies of all relevant correspondence and should be directed to the following address:

**Appeals Coordinator  
State Health Benefits Commission  
PO Box 299  
Trenton, NJ 08625-0299**

Notification of all Commission decisions will be made in writing to the member. If the Commission approves the member's appeal, the decision is binding upon the health plan. 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 (ALJ) 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's process. If you require an attorney or expert medical testimony, you will be responsible for any fees or costs incurred.

## **HMO PLAN STANDARDS**

The SHBP has established minimum coverage requirements and operating standards for all participating HMOs that safeguard our 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 the SHBP has imposed a mandatory expectation or requirement.

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 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.
- There will be a \$35 maximum copayment for emergency room services; 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 copayment 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 minimum 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.

## **2005 NEW JERSEY HMO PERFORMANCE REPORT: COMPARE YOUR CHOICES**

You can compare quality ratings of various HMO's with the New Jersey Department of Health and Senior Services' *New Jersey HMO Performance Report: Compare Your Choices*. A summary of selected report data, as it relates to HMOs in the SHBP, is provided in the chart below. As of this printing, the 2005 report is the latest report available.

From the health plans that seem to best fit your needs, check the issues that are most important to you and your family. For example, if you have a young child, you might be most interested in the performance measures in the Care for Kids section of the report. Be careful, however, not to make decisions based on small differences that are not meaningful. Look at all factors that contribute to a health plan's performance, not just results for a single measure.

To obtain a complete copy of the latest *New Jersey HMO Performance Report: Compare Your Choices*, contact the New Jersey Department of Health and Senior Services, Office of Managed-Care, PO Box 360, Trenton, NJ 08625-0360, or call 1-800-418-1397. The report is also available over the Internet at: [www.state.nj.us/health](http://www.state.nj.us/health)

<b>COMPARISON OF HEALTH MAINTENANCE ORGANIZATIONS BASED ON DEPARTMENT OF HEALTH AND SENIOR SERVICES — 2005 NJ HMO PERFORMANCE REPORT</b>				
<b>PLAN NAME</b>	<b>OVERALL PERFORMANCE</b>			
	<b>SERVICE AND ACCESS</b>	<b>DOCTORS AND MEDICAL CARE</b>	<b>STAYING HEALTHY</b>	<b>GETTING BETTER/LIVING WITH ILLNESS</b>
Aetna	●	◐	◐	◐
AmeriHealth	◐	◐	◐	◐
CIGNA HealthCare	◐	◐	◐	●
Health Net	◐	◐	◐	◐
Horizon HMO (see note)	◐	◐	●	●
Oxford Health Plan	◐	●	◐	◐
<b>Performance Compared to the Average</b>				
●	<b>Higher</b> than the New Jersey health plan average			
◐	<b>About the Same</b> as the New Jersey health plan average			
○	<b>Lower</b> than the New Jersey health plan average			
		<p><b>Note:</b> The provider network for <b>NJ PLUS in-network</b> benefits is the same as that for Horizon HMO.</p> <p>For rating details see the <i>New Jersey HMO Performance Report: Compare Your Choices</i>.</p>		

### **New Jersey Hospital Performance Report**

Also 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.

## **NOTICE OF PRIVACY PRACTICES TO ENROLLEES IN THE NEW JERSEY STATE 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.

**EFFECTIVE DATE: APRIL 14, 2003.**

### **Protected Health Information**

The State Health Benefits Program (SHBP) is 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 SHBP 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 SHBP through various sources, such as enrollment forms, employers, health care providers, federal and State agencies, or third-party vendors.

The SHBP is required by law to abide by the terms of this Notice. The SHBP reserves the right to change the terms of this Notice. If the SHBP makes material change to this Notice, a revised Notice will be sent.

### **SHBP Uses and Disclosures of PHI**

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

- The SHBP 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 SHBP may use PHI to bill the member for the appropriate premiums and reconcile billings we receive from our Business Associates.
- The SHBP may use and disclose PHI for fraud and abuse detection.
- The SHBP 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 SHBP may use and disclose PHI in response to a court or administrative order as provided by law.
- The SHBP 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 SHBP 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 SHBP will provide access to PHI only to the member, the member's authorized representative, and those organizations who need the information to aid the SHBP 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](http://www.state.nj.us/treasury/pensions) or by sending an e-mail to: [hipaaform@treas.state.nj.us](mailto:hipaaform@treas.state.nj.us). A member may revoke an authorization at any time.

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

### **Member Rights**

Members of the SHBP 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 SHBP maintains in a designated record set which consists of all documentation relating to member enrollment and the SHBP'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 SHBP 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 SHBP 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 SHBP; 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 SHBP 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 SHBP place restrictions on the use or disclosure of their PHI for treatment, payment, or health care operations purposes. The SHBP 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 SHBP 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 SHBP 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 SHBP using the information listed at the end of this Notice. (Local county, municipal, and Board of Education employees should contact the HIPPA Privacy Officer for their employer.)

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

**Contact Office:** The State Health Benefits Program—HIPAA Privacy Officer

**Address:** State of New Jersey  
Department of the Treasury  
Division of Pensions and Benefits  
Bureau of Policy and Planning  
PO Box 295  
Trenton, NJ 08625-0295

**Fax:** (609) 341-3410

**E-mail:** [hipaaform@treas.state.nj.us](mailto:hipaaform@treas.state.nj.us)

## TAX\$AVE

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, 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 same-sex domestic partners, on page 63).
- 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 Horizon Healthcare.)

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.htm](http://www.state.nj.us/treasury/pensions/taxsave.htm)

**Note:** The *Tax\$ave* program is not available to local employees. Contact your employer to find out if you are eligible to pay premiums on a pre-tax basis through an IRC Section 125 Program offered by your employer.

### Taxsave Open Enrollment

You may join a Tax\$ave or make changes to your Tax\$ave accounts during the Tax\$ave Open Enrollment period. Enrollment in the POP is automatic unless you decline enrollment each year. You can enroll in the UMSA or DCSA by calling Horizon Healthcare at 1-800-224-4426.

### 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” below).

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 marries, no longer lives at home, or turns age 23).
- A move outside an HMO service area.
- 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.
- A child, under the age of 23, has divorced and moves back into the employee’s household and is dependent upon the employee for support and maintenance.
- 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.

**DOMESTIC PARTNERS AND TAX\$AVE**

The Internal Revenue Service does not recognize a New Jersey 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 same-sex domestic partner SHBP benefit as federally taxable.

As a result, a 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 same-sex domestic partner can be reimbursed under the **Unreimbursed Medical Spending Account** and before any premiums that the employee pays for the same-sex domestic partner coverage can be made on a pre-tax basis under the **Premium Option Plan**. See IRS *Tax Topic 354 - Dependents* for additional information on the requirements for establishing dependent status for federal tax purposes.

If the same-sex domestic partner is **not** a “qualified tax dependent” of the employee, the domestic 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 domestic partner, nor make pre-tax payments for the cost of the 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 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 same-sex domestic partner SHBP benefit is subject to state taxes.

Additional information about the New Jersey Domestic Partnership Act can be found in Fact Sheet #71, *Benefits Under the Domestic Partnership Act*, which is available on the Division's Web site at: [www.state.nj.us/treasury/pensions](http://www.state.nj.us/treasury/pensions)

## STATE HEALTH BENEFITS PROGRAM CONTACT INFORMATION

Health plan telephone numbers and mailing addresses are located in the individual plan descriptions beginning on page 13.

### ADDRESSES

**Our Mailing Address is** ..... The State Health Benefits Program  
Division of Pensions and Benefits  
PO Box 299  
Trenton, NJ 08625-0299

**Our Internet Address is** ..... [www.state.nj.us/treasury/pensions/shbp.htm](http://www.state.nj.us/treasury/pensions/shbp.htm)

**Our E-mail Address is** ..... [pensions.nj@treas.state.nj.us](mailto: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 hrs. a day** ..... 1-866-EAS-9133  
..... 1-866-327-9133

**Rutgers University Personnel Counseling Service (EAP)** ..... (732) 932-7539

#### **New Jersey State Police**

**Employee Advisory Program (EAP)** ..... (856) 234-5652  
..... (908) 231-1077  
..... (609) 633-3718  
..... 1-800-FOR-NJSP

**University of Medicine and Dentistry of New Jersey (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** ..... 1-800-Medicare

New Jersey Medicare - Part A ..... 1-866-641-2007

New Jersey Medicare - Part B ..... 1-800-462-9306

## **STATE HEALTH BENEFITS PROGRAM PUBLICATIONS**

The publications and fact sheets available from the Division of Pensions and Benefits provide information on a variety of subjects. Employees and retirees can obtain copies of these publications from their employers or by contacting the Division.

Fact sheets and other publications are also available for viewing or downloading over the Internet at: [www.state.nj.us/treasury/pensions](http://www.state.nj.us/treasury/pensions)

### **General Publications**

*State Health Benefits Program Comparison Summary* - Plan comparison chart.

### **SHBP Fact Sheets**

Fact Sheet #11, *Enrolling in the State Health Benefits Program When you Retire.*

Fact Sheet #23, *The State Health Benefits Program 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 New Jersey State Health Benefits Program Coverage Under COBRA.*

Fact Sheet #37, *SHBP Employee Dental Plans.*

Fact Sheet #47, *SHBP Retired Coverage Under Chapter 330 - PFRS & LEO.*

Fact Sheet #51, *Continuing SHBP Coverage for Over Age Children with Disabilities.*

Fact Sheet #60, *Voluntary Furlough Program.*

Fact Sheet #66, *SHBP Coverage for State 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, *SHBP Coverage of Children to Age 30 Under Chapter 375, P.L. 2007.*

### **SHBP Health Plan Member Handbooks and Other Resources**

*SHBP NJ PLUS Member Handbook*

*SHBP Traditional Plan Member Handbook*

SHBP HMO member handbooks are available from the individual HMOs.

NJ HMO Performance Report (see page 57).

**SHBP Member Handbooks for Other Benefit Plans**

*SHBP Employee Prescription Drug Plan Member Handbook*

*SHBP Employee Dental Plans Member Handbook*

*SHBP Retiree Dental Expense Plan Member Handbook*

**NOTES**



