



Willingboro Public Schools

Where Excellence is the Expectation

DR. NEELY HACKETT

SUPERINTENDENT OF SCHOOLS

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WBOE New Hire Health Benefits

Full-time employees hired after 7/1/2020 at Willingboro Public Schools are eligible for the NJ Educators Health Plan for themselves and eligible benefits. This is a state-sponsored PPO plan through Horizon Blue Cross Blue Shield. There is a two-month waiting period for benefits to begin unless employees are hired on September 1st or transferring the state-sponsored plan from their previous employer. Alternatively, full-time employees may opt out of medical/Rx benefits. After one year of waiving coverage, employee eligibility will be tracked for waiver reimbursements which are issued twice a year. Benefit summaries have been attached to this email. Please make your selections and return enrollment forms within 30 days of your full-time start date.

Medical/Rx: To enroll in the NJ Educators Health Plan, you'll receive an email from the state's online benefits system, Benefitsolver. Please note that failure to provide the proper documentation in the Benefitsolver system may cause coverage to be delayed or denied. Eligible dependents for medical/Rx include spouse, same-sex civil union partner, or child(ren) up to age 26. Child dependents are eligible through the end of the calendar year they turn 26. Our NJ EHP prescription coverage mirrors the state prescription plan but is managed through a private plan. Please return the completed Horizon Rx form to the WBOE Human Resources Department.

For additional information regarding the SEHBP NJ Educators Health Plan please use the link and/or phone numbers below.

- o **Horizon BCBSNJ Website**
- o **Horizon Member Services: 1-800-414-SHBP (1-800-414-7427)**

Waiver Form: To opt-out of coverage, please complete the appropriate sections of Benefitsolver and provide proof of current insurance coverage. There is also a district Waiver Form for completion. After waiving medical/Rx benefits for one year, an employee's eligibility to receive waiver reimbursement will be tracked. Waiver forms and proof of medical coverage may be required annually to continue eligibility for waiver reimbursement.

Dental Coverage: Full-time employees may also enroll in one of the district's Delta Dental plans, regardless of medical/Rx enrollment. Plan designs are attached and the cost will be included below. To enroll, please fill out the attached Delta Dental Enrollment Form with your personal information and include any eligible dependents. Eligible dependents can be a spouse, same-sex civil union partner, or child(ren) up to age 23 (regardless of full-time student status). Child dependents are eligible for coverage through the end of the calendar year they turn 23.

2021 Delta Dental Standard Plan		
Plan Size	Annual Premium	Employee Per Pay Deduction for 20 Pays (no July or August contributions)
Single	\$320.52	\$9.78
Family	\$734.76	\$24.99

2021 Delta Dental Premier Plan		
Plan Size	Annual Premium	Employee Per Pay Deduction for 20 Pays (no July or August contributions)
Single	\$422.04	\$14.86
Family	\$1,472.64	\$61.89

Full-time employees of WBOE are also eligible for a Life Insurance and Accidental Death & Dismemberment plan through Boston Mutual Life Insurance Company. There is no charge to employees for this coverage, but a signed enrollment form must be on file for coverage. Please complete and return the attached Boston Mutual enrollment form to WBOE Human Resources in order to activate your coverage.

If you are interested in Section 125 options or Flexible Spending Accounts, please contact the district's Aflac representatives.

Once you've had a chance to review this material, please let me know if you have any questions.

Kind regards,

Casey Colona
WBOE Benefits Specialist
ccolona@wboe.net
 609.835.8600 Ext. 1002



Aflac for Willingboro Public School District Employees

*****Willingboro Public School District employees are NOT covered under NJ State Disability*****

Short Term Disability- Paycheck insurance if you are out of work due to an injury, pregnancy, or illness (Covid included!)

Accident- 24/7 Coverage for your family that eases expenses that come with bumps, breaks, and much more.

Hospitalization- Great for pregnancy and hospital admissions.

Cancer- Payouts for diagnosis, treatments, travel and much more. No cost for children.

Lump Sum CI- Lump sum amount for Heart Attack, Stroke, Coma, Paralysis & Renal Failure.

Life Insurance- Whole, Term & Juvenile coverage available!

Dental Policy- A great supplement that helps with out of pocket expenses & deductibles.

Your Agents- Linda Dunfee | Alison Young

Phone: 609.617.9084 | 609.221.9587

Email: linda_dunfee@us.aflac.com | alison_young@us.aflac.com

Board Approved Tax Shelter 403(b) Companies

ING Life Insurance and Annuity Company	856-439-5100
ReliaStar Life Insurance Company	856-439-5100
Oppenheimer Funds	800-525-7048
Metropolitan Life Insurance Company	732-652-1200
AXA Equitable Life Insurance Company	315-477-4010
Valic	888-478-7020
Lincoln Investment Planning	800-242-1421
Midland National	856-642-4074



Explore Your Benefits

LOCAL EDUCATION ACTIVE GROUP MEDICAL PLAN DESIGN - PLAN YEAR 2021 HORIZON PLANS - MEDICAL COST SHARING

	NJ DIRECT10	NJ DIRECT15	NEW JERSEY EDUCATORS HEALTH PLAN
Medical Cost Sharing			
Primary Care Copayment	\$10	\$15	\$10
Specialist Care Copayment	\$10	\$15	\$15
Emergency Room Copayment	\$25	\$50	\$125
In-Network Deductible			
In-Network Coinsurance	10% ¹	10% ¹	10% ¹
In-Network Coinsurance Maximum (Individual/Family)		\$400/\$1,000	
In-Network Out-of-Pocket Maximum (Individual/Family)	\$400/\$1,000	\$6,840/\$13,680	\$500/\$1,000
Out-of-Network Deductible (Individual/Family)	\$100/\$250	\$100/\$250	\$350/\$700
Out-of-Network Coinsurance ²	20%	30%	30% ³
Out-of-Network Out-of-Pocket Maximum (Individual/Family)	\$2,000/\$5,000	\$2,000/ \$5,000	\$2,000/\$5,000
Out-of-Network In Patient Hospital Deductible	Out-of-Network Deductible applies (see above)	Out-of-Network Deductible applies (see above)	Out-of-Network Deductible applies (see above)
Out-of-Network Chiropractic Services	Lesser of \$35/visit or 75% of In-Network cost/visit	Lesser of \$35/visit or 75% of In-Network cost/visit	Lesser of \$35/visit or 75% of In-Network cost/visit
Out-of-Network Acupuncture Services	Lesser of \$60/visit or 75% of In-Network cost/visit	Lesser of \$60/visit or 75% of In-Network cost/visit	Lesser of \$60/visit or 75% of In-Network cost/visit
Out-of-Network Physical Therapy Services	Lesser of \$52/visit or 75% of In-Network cost/visit	Lesser of \$52/visit or 75% of In-Network cost/visit	Lesser of \$52/visit or 75% of In-Network cost/visit

¹ On Select Services

² After Deductible

³ Out of Network Allowance is 200% of CMS Fee Schedule



LOCAL EDUCATION ACTIVE GROUP MEDICAL PLAN DESIGN - PLAN YEAR 2021 HORIZON PLANS - MEDICAL COST SHARING

	NJ DIRECT10	NJ DIRECT15	NEW JERSEY EDUCATORS HEALTH PLAN
Prescription Drug Copayments*			
Retail: Generic Copayments	\$3	\$3	\$5
Retail: Preferred Brand Copayments	\$10	\$10	\$10
Retail: Non-Preferred Brand Copayments	\$10	\$10	Member pays difference ⁴
Mail: Generic Copayments	\$5	\$5	\$10
Mail: Preferred Brand Copayments	\$15	\$15	\$20
Mail: Non-Preferred Brand Copayments	\$15	\$15	Member pays difference ⁴
Prescription Drug annual Out-of-Pocket Maximum (Individual/Family)	\$1,710/\$3,420	\$1,710/\$3,420	\$1,600/\$3,200

Note: Retail – 30 day supply. Mail – 90 day supply. Oral contraceptive coverage is available under the medical and prescription plans.

* Local education employers can select from the SEHBP's Prescription Drug Plans, purchase their own prescription drug coverage plan, or receive prescription drug coverage through the SEHBP medical plan. Copayments shown apply to the plans when coverage is through the SEHBP's Prescription Drug Plans. If prescription drug coverage is through the medical plan: for NJ DIRECT10 and NJ DIRECT15, coinsurance is 10%; for NJEHP, copays are the same as if coverage is through the SEHBP's Prescription Drug Plan as shown in the chart above.

⁴ You pay the applicable brand copayment as listed above, plus the cost difference between the brand drug and the generic drug.

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This is a summary and not intended to provide all information. Although every attempt at accuracy is made, it cannot be guaranteed.

P.L. 2020, Chapter 44

Frequently Asked Questions

ABOUT CHAPTER 44

1. Q. What is Chapter 44?

A. On July 1, 2020, Governor Murphy signed P.L. 2020, Chapter 44 (S2273/A20), which will reduce the health care contributions for certain school employees who elect the newly created New Jersey Educators Health Plan (NJEHP) or the Garden State Health Plan (GSHP). The GSHP will be available July 1, 2021, for new employees who are hired after July 1, 2021, and for those having a qualifying event. All other employees will be able to enroll in the GSHP for Plan Year 2022 during the designated open enrollment.

In addition, Chapter 44 calls for a change in the reimbursement of physical therapy, acupuncture, and chiropractic services provided by out-of-network health care professionals for all School Employees' Health Benefits Program (SEHBP) plans as of **August 1, 2020**.

2. Q. What health plans will be available to SEHBP members during Open Enrollment in the Fall of 2020?

A. All new employees hired *on or after* July 1, 2020, will have the option to enroll in the New Jersey Educators Health Plan (NJEHP) or waive coverage.

All employees hired *prior to* July 1, 2020, will be enrolled in the NJEHP unless that member affirmatively elects to waive coverage, **or** affirmatively elects to remain enrolled in either NJ DIRECT10 or NJ DIRECT15.

Eligible individuals who affirmatively elect to remain enrolled in NJ DIRECT10 or NJ DIRECT15 will continue to pay contributions based upon the Chapter 78 contribution grid or pursuant to their existing collective negotiation agreement (CNA). The Chapter 78 contribution grid can be found on the Division of Pensions & Benefits website: www.nj.gov/treasury/pensions

All other plans currently offered by the SEHBP (NJ DIRECT ZERO, NJ DIRECT1525, NJ DIRECT2030, Horizon HMO, Horizon HMO1525, Horizon HMO2030, Horizon HMO2035, NJ DIRECT HD1500) will no longer be available as plan options.

PLAN COSTS

3. Q. What do contributions look like under the NJEHP?

A. Employees and certain retirees* are required to contribute a percentage of their base salary or retirement allowance (including any cost-of-living adjustment) as applicable. See the chart below.

Salary/Ret. Allowance*	Coverage Level Percentages			
	Single	Parent & Child	Member & Spouse/Partner	Family
\$40,000 or Less	1.7%	2.2%	2.8%	3.3%
>\$40,000 to \$50,000	1.9%	2.5%	3.3%	3.9%
>\$50,000 to \$60,000	2.2%	2.8%	3.9%	4.4%
>\$60,000 to \$70,000	2.5%	3.0%	4.4%	5.0%
>\$70,000 to \$80,000	2.8%	3.3%	5.0%	5.5%
>\$80,000 to \$90,000	3.0%	3.6%	5.5%	6.0%
>\$90,000 to \$100,000	3.3%	3.9%	6.0%	6.6%
>\$100,000 to \$125,000	3.6%	4.4%	6.6%	7.2%
More than \$125,000	Percentage to be contributed shall be the same as for a base salary/allowance of \$125,000.			

* Applies to retirees who are not Medicare-eligible and who are required by another provision of law to contribute in retirement toward the cost of health benefits coverage under the SEHBP.

PLAN ROLLOUT

4. Q. What coverage do employees receive who were hired on or after July 1, 2020, between the time of hire and January 1, 2021, when the new NJEHP will become available?

A. If an employee is hired after July 1, 2020, but prior to December 31, 2020, the employee will receive whatever health benefits options a new employee would otherwise be entitled to under their existing CNA. Such an employee will have the ability to waive coverage during open enrollment, and in the absence of such a waiver of coverage that employee and any applicable dependents will be enrolled in the NJEHP as of January 1, 2021.

5. Q. If an employee who was hired prior to July 1, 2020, elects to join the NJEHP for Plan Year 2021, are they able to move back to NJ DIRECT10 or NJ DIRECT15?

A. Yes. Employees hired prior to July 1, 2020, have the option to switch to NJ DIRECT10, NJ DIRECT15, or the NJEHP. Plan changes may only occur during a designated enrollment period or immediately following a qualifying HIPAA event.

PLAN DESIGN

6. Q. What is the Plan Design of the New Jersey Educator's Health Plan?

Medical Coverage and Copayment(s)/Coinsurance

New Jersey Educators Health Plan	
Primary Care Copayment	\$10
Specialist Care Copayment	\$15
Emergency Room Copayment	\$125 (to be waived if admitted)
In-Network Deductible	\$0
In-Network Coinsurance	10% applicable to Emergency Transportation and Durable Medical Equipment
In-Network Out-of-Pocket Maximum (Individual/Family)	\$500 single/\$1,000 Family (covers all in network copayments, coinsurance, and deductible)
Out-of-Network Allowance	200% CMS
Out-of-Network Deductible (Individual/Family)	\$350 single/\$700 Family
Out-of-Network Coinsurance	30% of out-of-network fee schedule
Out-of-Network Out-of-Pocket Maximum (Individual/Family)	\$2,000/\$5,000
Out-of-Network Inpatient Hospital Deductible	Out-of-Network Deductible applies (see above)
Out-of-Network Physical Therapy Services	75% of in-network cost/service (\$52)
Out-of-Network Acupuncture Services	Lesser of \$60/visit or 75% of in-network cost/visit
Out-of-Network Chiropractic Services	Lesser of \$35/visit or 75% of in-network cost/visit

Prescription Drug Coverage and Copayment(s)

Retail: Generic	\$5 – 30-day supply
Retail: Preferred Brand	\$10 — 30-day supply
Retail: Non-Preferred Brand	Member Pays Difference between generic and brand plus brand copayment**
Mail: Generic	\$10 – 90-day supply
Mail: Preferred Brand	\$20 — 90-day supply
Mail: Non-Preferred Brand	Member pays difference between generic and brand plus brand copayment**
Prescription Drug annual Out-of-Pocket Maximum (Individual/Family)	\$1,600 single/\$3200 family (Indexed Annually Pursuant to Federal Law)

***This cost to the member does not apply to the out-of-pocket maximum*

7. Q. What are the major differences between the NJ DIRECT10 / NJ DIRECT15 Plans and the NJEHP?

A. The most significant differences are an increase in copayment for emergency room visits that do not result in a hospital admission, the out-of-network deductible and coinsurance, and a different reimbursement schedule for all out-of-network providers. Members will still be able to utilize the same network of providers with the NJEHP as they did with NJ DIRECT.

For prescription drugs, there will be a closed formulary, an increase in most copayments, and mandatory use of generic drugs when they are available.

8. Q. Will SEHBP participating school districts be able to continue offering Medical coverage only, and separately procuring Prescription Drug benefits?

A. Participating school districts will be able to continue offering Medical coverage only, or Medical and Prescription Drug through the SEHBP.

9. Q. If a participating school district offers Medical coverage through the SEHBP and separately procures Prescription Drug coverage, are there any requirements on what that Prescription Drug plan must be?

A. If an SEHBP employer offers a standalone Prescription Drug plan, the plan offered to employees must have the same Plan Design as the NJEHP (see above) and provide equivalent coverage.

10. Q. Does Chapter 44 apply to Charter Schools and Renaissance Schools in New Jersey?

A. Yes. Chapter 44 applies to Charter Schools and Renaissance Schools.

11. Q. Can participating SEHBP school districts block member enrollment in the SEHBP plans that will be available on January 1, 2021? (For example, can an SEHBP employer “block” the NJ DIRECT10 or NJ DIRECT15 plans for their employees?)

A. No. Chapter 44 mandates that the SEHBP shall offer three plan options for employees hired prior to July 1, 2020, and one plan option (the NJEHP) for those employees hired on or after July 1, 2020 (and once created the GSHP, see below).

GARDEN STATE HEALTH PLAN

12. Q. What is the Garden State Health Plan?

A. The Garden State Health Plan (GSHP) will be created by the School Employees’ Health Benefit Program Plan Design Committee (SEHBP PDC) by December 31, 2020, or the Department of the Treasury, Division of Pensions & Benefits, if the SEHBP PDC has not done so by the legislatively mandated deadline. Chapter 44 requires that the GSHP include only New Jersey-based providers, with certain exceptions as set forth in the plan documents.

13. Q. What is the Plan Design of the GSHP?

A. Chapter 44 requires that the Plan Design of the GSHP be the same as the Plan Design for the NJEHP. (see charts above).

14. Q. When is the GSHP going to be available?

A. The GSHP will be available to newly hired employees after July 1, 2021, and will be available as a plan option to all employees during the Open Enrollment period held in 2021. Also, any employees experiencing a qualifying life event between July 1, 2021, and January 1, 2022, will have the ability to select the GSHP as a plan option.

15. Q. Why is the employee contribution for the GSHP one-half (50%) of the NJEHP employee contribution?

A. Chapter 44 states that the contribution for the GSHP will be 50% of the NJEHP (or a minimum of 1.5 percent of salary/retirement allowance). The SEHBP PDC, or the Division of Pensions & Benefits, as appropriate, will develop the GSHP accordingly.

RETIREEES

16. Q. Does Chapter 44 impact non-Medicare Eligible Retirees?

A. Yes. Chapter 44 mandates that all non-Medicare Retirees in the SEHBP must be enrolled in the NJEHP. Non-Medicare Retirees will not have the option to enroll in any other plan; however, they will have the ability to waive coverage on a yearly basis.

Non-Medicare Eligible Retirees who are required to share the cost of SEHBP coverage in retirement, will contribute a percentage of retirement allowance when enrolled in the NJEHP.

17. Q. Does Chapter 44 impact Medicare-Eligible Retirees?

A. No. Medicare-Eligible Retirees maintain their current plan choices and contribution schedules.

OUT-OF-NETWORK RIMBURSEMENT CHANGES

18. Q. Why are out-of-network reimbursements changing?

A. Chapter 44 calls for a new out-of-network reimbursement structure comparable to the structure of the State Health Benefits Program. This includes out-of-network reimbursements for physical therapy, acupuncture, and chiropractic care, along with other services at 200 percent of Centers for Medicare & Medicaid Services (CMS) reimbursement amounts.

19. Q. When does the out-of-network reimbursement change become effective?

A. The new reimbursement changes were effective as of **August 1, 2020**.

20. Q. How are reimbursements changing?

A. If you use an out-of-network provider for physical therapy, acupuncture, or chiropractic services, you must meet your annual deductible. Then, you will pay the coinsurance amount (20 percent, 30 percent, or 40 percent) for your plan, plus any amount exceeding the out-of-network benefit limits shown below:

- ✓ Physical Therapy: **\$52 per visit**
- ✓ Acupuncture for Pain Management: **\$60 per visit**
- ✓ Chiropractic Services: **\$35 per visit**

Please Note: There is a 30-visit maximum per calendar year for both in-network and out-of-network chiropractic services.

21. Q. Which plans are impacted by the out-of-network reimbursement change?

A. This change applies to all plans.

22. Q. Can I continue to receive out-of-network physical therapy, acupuncture, or chiropractic services?

A. Yes. However, you will be subject to out-of-network coinsurance if you see an out-of-network provider and may be able to save money when you receive these services from an in-network provider.

23. Q. Will the new out-of-network reimbursement apply to the new NJEHP?

A. Yes. The reimbursement changes will be applied to the NJEHP when it becomes effective.

24. Q. Is the out-of-pocket maximum for the health plan separate from the prescription drug out-of-pocket maximum?

A. Yes. The out-of-pocket costs for the health plan and the prescription drug plan are separate.

25. Q. Can the difference paid between generic and non-preferred brand prescription drugs be applied to the out-of-pocket maximum?

A. No. Any difference paid between generic and non-preferred brand prescription drugs is not to be applied to the out-of-pocket maximum.



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** Benefits may change upon renewal. For more information about your coverage, or to get a copy of the complete terms of coverage, visit Member Online Services at <http://www.nj.gov/treasury/pensions/index.shtml> or by calling 1-609-292-7524. If you do not currently have coverage with Horizon BCBSNJ you can view a sample policy here, <http://www.nj.gov/treasury/pensions/index.shtml>. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.ccio.cms.gov or call 1-609-292-7524 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$350.00 Individual / \$700.00 Family for out-of-network providers. Aggregate family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For Active employee in-network Health providers \$500.00 Individual/ \$1,000.00 Family. Retiree in-network Health providers \$500.00 Individual/ \$1,000.00 Family. Out-of-network providers \$2,000.00 Individual/ \$5,000.00 Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of in-network providers, see www.HorizonBlue.com/shbp or call 1-800-414-SHBP (7427).	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$10.00 <u>Copayment</u> per visit.	30% <u>Coinsurance</u> .	Out-of-network allowances for Chiropractic, Acupuncture and Physical Therapy services are limited to no more than \$35.00 per visit for Chiropractic, \$60.00 per visit for Acupuncture and \$52.00 per visit for Physical Therapy or 75% of the in network cost per visit, whichever is less.
	Specialist visit	\$15.00 <u>Copayment</u> per visit.	30% <u>Coinsurance</u> .	
	Preventive care/ screening/immunization	No Charge.	Not Covered.	
If you have a test	Diagnostic test (x-ray, blood work)	No Charge.	30% <u>Coinsurance</u> .	One per calendar year. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Imaging (CT/PET scans, MRIs)	No Charge.	30% <u>Coinsurance</u> .	Requires pre-approval.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available through your employer.	Generic drugs	See separate Prescription Drug Plan SBC		none
	Preferred brand drugs			none
	Non-preferred brand drugs			none
	Specialty drugs			none
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge.	30% <u>Coinsurance</u> .	none
	Physician/surgeon fees	No Charge.	30% <u>Coinsurance</u> .	30% <u>Coinsurance</u> for out-of-network anesthesia.
If you need immediate medical attention	Emergency room care	\$125.00 <u>Copayment</u> per visit for Outpatient Hospital.	\$125.00 <u>Copayment</u> per visit for Outpatient Hospital. <u>Deductible</u> does not apply.	If admitted within 24 hours, the copayment is waived. Payment at the in-network level applies only to true Medical Emergencies & Accidental Injuries.

* For more information about limitations and exceptions, see the plan or policy document at <http://www.nj.gov/treasury/pensions/index.shtml>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Emergency medical transportation</u>	10% <u>Coinsurance</u> .	30% <u>Coinsurance</u> .	Limited to local emergency transport to the nearest facility equipped to treat the emergency condition.
	<u>Urgent care</u>	\$15.00 <u>Copayment</u> per visit.	30% <u>Coinsurance</u> .	none
	Facility fee (e.g., hospital room)	No Charge for Inpatient Hospital.	30% <u>Coinsurance</u> for Inpatient Hospital.	Requires pre-approval.
	Physician/surgeon fees	No Charge for Inpatient Hospital.	30% <u>Coinsurance</u> for Inpatient Hospital.	Requires pre-approval. 30% <u>Coinsurance</u> for out-of-network anesthesia.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge for Outpatient Hospital. \$15.00 <u>Copayment</u> per Office Visit for Mental Health and Behavioral Health. No Charge for Substance Abuse Office Visit.	30% <u>Coinsurance</u> for Outpatient Hospital.	Some specialty outpatient services require pre-approval.
	Inpatient services	No Charge for Inpatient Hospital.	30% <u>Coinsurance</u> for Inpatient Hospital.	Requires pre-approval.
If you are pregnant	Office visits	\$10.00 <u>Copayment</u> per visit for Office. \$15.00 <u>Copayment</u> per visit for Office; Specialist.	30% <u>Coinsurance</u> .	<u>Cost sharing</u> does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. Ultrasound.)
	Childbirth/delivery professional services	No Charge.	30% <u>Coinsurance</u> .	none
	Childbirth/delivery facility services	No Charge.	30% <u>Coinsurance</u> .	Requires pre-approval.

* For more information about limitations and exceptions, see the plan or policy document at <http://www.nj.gov/treasury/pensions/index.shtml>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge.	30% <u>Coinsurance</u> .	Requires pre-approval.
	<u>Rehabilitation services</u>	No Charge for Inpatient and Outpatient Facility. \$15.00 <u>Copayment</u> per visit for Office.	30% <u>Coinsurance</u> .	Requires pre-approval. Out-of-network allowance for Physical Therapy services is limited to \$52.00 per visit or 75% of the in network cost per visit, whichever is less.
	<u>Habilitation services</u>	No Charge for Inpatient and Outpatient Facility. \$15.00 <u>Copayment</u> per visit for Office.	30% <u>Coinsurance</u> .	
	<u>Skilled nursing care</u>	No Charge.	30% <u>Coinsurance</u> .	Requires pre-approval. Limited to 120 days in-network and 60 out-of-network facility days for a combined maximum of 120 days per calendar year.
If your child needs dental or eye care	<u>Durable medical equipment</u>	10% <u>Coinsurance</u> .	30% <u>Coinsurance</u> .	Requires pre-approval for all rentals and some purchases.
	<u>Hospice services</u>	No Charge.	30% <u>Coinsurance</u> .	Requires pre-approval.
	Children's eye exam	\$15.00 <u>Copayment</u> per visit.	Not Covered.	Coverage is limited to 1 visit.
	Children's glasses	Not Covered.	Not Covered.	_____none_____
	Children's dental check-up	Not Covered.	Not Covered.	_____none_____

* For more information about limitations and exceptions, see the plan or policy document at <http://www.nj.gov/treasury/pensions/index.shtml>

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Long Term Care
- Routine foot care
- Dental care (Adult)
- Private-duty nursing
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (for pain management only)
- Hearing Aids (Only covered for members age 15 or younger)
- Non-emergency care when traveling outside the U.S. (Subject to deductible/coinsurance and balance billing.)
- Bariatric surgery (requires pre-approval)
- Infertility treatment (requires pre-approval)
- Routine eye care (Adult)
- Chiropractic care (limited to 30 visits/year)
- Most coverage provided outside the United States. (Subject to deductible/coinsurance and balance billing.)

* For more information about limitations and exceptions, see the plan or policy document at <http://www.nj.gov/treasury/pensions/index.shtml>

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-414-7427 (SHBP), the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov, or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.getcovered.nj.gov or call 1-877-962-8448.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Horizon Blue Cross Blue Shield of New Jersey Member Services at 1-800-414-SHBP (7427). You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

-----To see examples of how this plan might cover costs for a sample medical situation, see the next section.-----

* For more information about limitations and exceptions, see the plan or policy document at <http://www.nj.gov/treasury/pensions/index.shtml>



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$0.00
- Specialist Copayment \$15.00
- Hospital (facility) Coinsurance 0%
- Other Coinsurance 10%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700.00
---------------------------	--------------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$20.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$70.00
The total Peg would pay is	\$90.00

Please note that some of the Limits or Exclusions listed above may be covered under the Prescription Plan.

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$0.00
- Specialist Copayment \$15.00
- Hospital (facility) Coinsurance 0%
- Other Coinsurance 10%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600.00
---------------------------	-------------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$100.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$4,300.00
The total Joe would pay is	\$4,400.00

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$0.00
- Specialist Copayment \$15.00
- Hospital (facility) Coinsurance 0%
- Other Coinsurance 10%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800.00
---------------------------	-------------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$200.00
Coinsurance	\$100.00
<i>What isn't covered</i>	
Limits or exclusions	\$10.00
The total Mia would pay is	\$310.00

This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.



Notice of Nondiscrimination

Horizon Blue Cross Blue Shield of New Jersey complies with applicable Federal civil rights laws and does not discriminate against nor does it exclude people or treat them differently on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations. Horizon BCBSNJ provides free aids and services to people with disabilities (e.g. qualified sign language interpreters and information in other formats) and to those whose primary language is not English (e.g. information in other languages) to communicate effectively with us.

Contacting Member Services

Please call Member Services at **1-800-355-BLUE (2583) (TTY 711)** or the **phone number on the back of your member ID card**, if you need the free aids and services noted above and for **all other Member Services issues**.

Filing a Section 1557 Grievance

If you believe that Horizon BCBSNJ has failed to provide the free communication aids and services or discriminated against you for one of the reasons described above, you can file a discrimination complaint also known as a Section 1557 Grievance. **Horizon BCBSNJ's Civil Rights Coordinator** can be reached by calling the Member Services number on the back of your member ID card or by writing to the following address: **Horizon BCBSNJ**

Civil Rights Coordinator
PO Box 820, Newark, NJ 07101.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, through the Office for Civil Rights Complaint Portal, online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail at **U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201** or by phone at **1-800-368-1019** or **1-800-537-7697 (TDD)**. OCR Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Language assistance

Si habla un idioma diferente al inglés, hay ayuda disponible gratis. Llame al número que aparece al reverso de su tarjeta de identificación. 如果您讲英语以外的语言，可获取免费帮助。请拨打您的身份证背面的号码。

영어 이외의 언어를 사용하는 경우, 무료 지원 서비스를 받을 수 있습니다. ID 카드 뒷면에 있는 번호로 전화하십시오.

Se você fala um idioma diferente do inglês, a ajuda está disponível gratuitamente. Ligue para o número no verso do seu bilhete de identidade. જો તમે અંગ્રેજી સિવાયની ભાષા બોલતા હોવ, તો મફતમાં મદદ ઉપલબ્ધ છે. તમારા આઈડી કાર્ડની પાછળ આપેલા નંબર પર કોલ.

Jesli mówisz w języku innym niż angielski, pomoc udzielana jest bezpłatnie. Zadzwoń pod numer podany na odwrocie dowodu osobistego. Se parli una lingua diversa dall'inglese, è disponibile un servizio di assistenza gratuito. Chiama il numero sul retro della tua carta d'identità.

Kung nagsasalita ka ng isang wika maliban sa Ingles, magagamit ang tulong nang walang bayad. Tumawag sa numerong nasa likod ng iyong ID card.

Если вы не говорите по-английски, вам помогут бесплатно. Позвоните по телефону, указанному на обратной стороне ваших ID-карты.

Si ou pale on lòt lang ke Angle, gen ed ki disponib gratis. Rele nan nimewo ki ekri nan do kat idantifyan w lan.

यदि आप अंग्रेजी से भिन्न कोई अन्य भाषा बोलते हैं, तो निःशुल्क सहायता उपलब्ध है। अपने आईडी कार्ड के पीछे दिए गए नंबर पर .

Nếu bạn nói ngôn ngữ khác ngoài tiếng Anh, thì chúng tôi có thể giúp bạn miễn phí. Hãy gọi số ở mặt sau thẻ ID của bạn.

Si vous parlez une langue autre que l'anglais, l'aide est gratuite. Appelez le numéro au dos de votre carte d'identité.

إذا كنت تتحدث لغة أخرى غير الإنجليزية، توفر لك المساعدة مجاناً. يُمكنك الاتصال بالرقم الموجود على ظهر بطاقة الهوية. اگر آپ انگریزی کے علاوہ کوئی دوسری زبان بول سکتے ہیں تو مفت مدد دستیاب ہے۔ براہ مہربانی شناختی کارڈ کی پچھلی طرف درج نمبر پر کال کریں۔

CNC0008179_A (06-19)

An Independent Licensee of the Blue Cross and Blue Shield Association.

* For more information about limitations and exceptions, see the [plan](http://www.nj.gov/treasury/pensions/index.shtml) or policy document at <http://www.nj.gov/treasury/pensions/index.shtml>



WILLINGBORO BOARD OF EDUCATION
GROUP # 7666
Delta Dental PPOSM
plus Premier

	Standard Plan	Premium Plan
Preventive & Diagnostic	100%	100%
* Exams, Cleanings, Bitewing x-rays (each subject to frequency limitations)		
* Fluoride Treatment (subject to frequency limitations, children to age 19)		
Sealants	100%	90%
Remaining Basic		
* Fillings, Extractions	60%	90%
* Endodontics (root canal)		
* Periodontics, Oral Surgery		
* Repair of Dentures		
Crowns & Prosthodontics	50%	60%
* Crowns, Gold Restorations		
* Bridgework		
* Full & Partial Dentures		
* Implants		
Calendar Year Maximum (per person)	\$1,000	\$2,500
Calendar Year Deductible (waived on Preventive & Diagnostic)		
* Per Person	\$25	None
* Family Aggregate Deductible	\$75	None
Orthodontic Benefits	50%*	50%**
* Lifetime Maximum (per person)	\$1,500	\$2,500
	*Child Only	*Child & Adult

Over 248,000 participating dental offices nationwide participate with the national Delta Dental system, although you may choose any fully licensed dentist to render necessary services. Participating dentists will be paid directly by Delta Dental to the extent that services are covered by the contract. Non-participating dentists will bill the patient directly, and Delta Dental will make payment directly to the member. Maximum benefit may be derived by utilizing the services of a participating dentist.

Where the eligible patient is treated by a Delta Dental PPO dentist, the fee for the covered service(s) will not exceed the Delta Dental PPO maximum allowable charge(s). Where the eligible patient is treated by a Delta Dental Premier dentist who does not participate in Delta Dental PPO or by a *Participating Specialist*, the dentist has agreed not to charge eligible patients more than the dentist's filed fee or Delta Dental's established maximum plan allowance, and Delta Dental will pay such dentists based on the least of the actual fee, the filed fee, or Delta Dental's established maximum plan allowance for the procedure(s). Claims for services provided by dentists who are neither Delta Dental Premier, Delta Dental PPO dentists, or *Participating Specialists* are paid based on the lesser of the dentist's actual charge or the prevailing fee.

Visit your own dentist. If you do not have a dentist, there is a directory available with your plan administrator listing participating dentists. You may call 1-800-DELTA-OK and a list of participating dentists located in your area will be mailed directly to your home, or you may access our Website at www.delladentalnj.com.

During your FIRST appointment, tell your dentist that you are covered under this program. Give him/her your Group's name, its Delta Dental Group Number and your Social Security number. Your dependents, if covered, should give YOUR SOCIAL SECURITY NUMBER.

If you have any questions regarding your benefits, you may contact our Customer Service Department Monday through Thursday, 8:00 a.m. to 6:30 p.m. EST and Friday, 8:00 a.m. to 5:00 p.m. EST, at 1-800-452-9310.

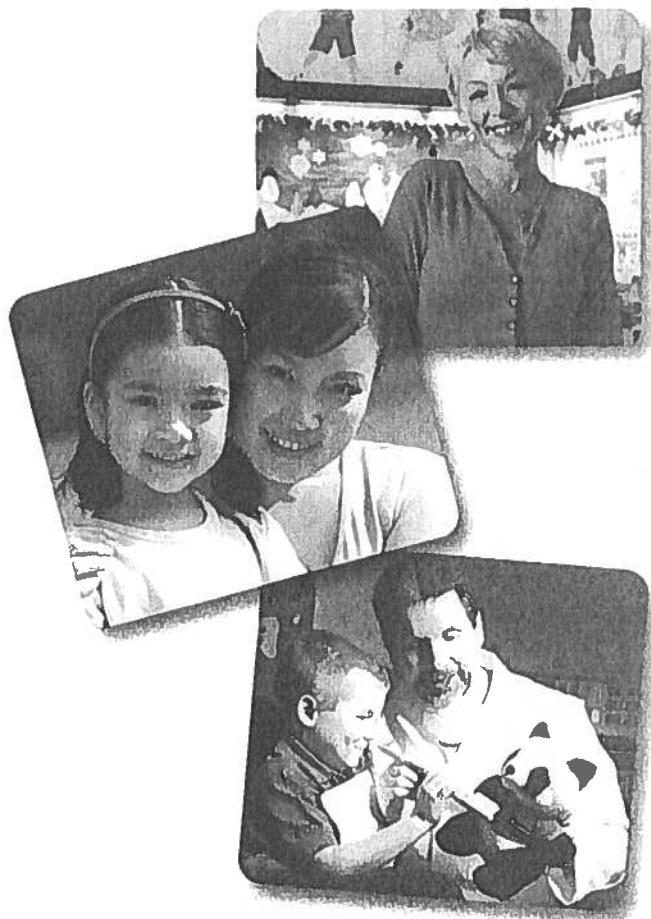
This overview contains a general description of your dental care program for your use as a convenient reference. Complete details of your program appear in the group contract between your plan sponsor and Delta Dental of New Jersey, Inc. which governs the benefits and operation of your program. The group contract would control if there should be any inconsistency or difference between its provisions and the information in this overview.

U&A _____



Everyone Deserves a Healthy Smile

Thank you for choosing Delta Dental. Our goal is to provide you and your covered dependents with the highest quality dental benefit program. We are committed to helping you improve your oral health while providing access to the nation's largest network of dental providers.

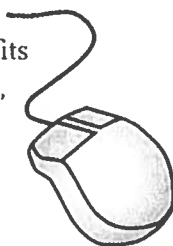


Convenience That Counts

Benefits Connection. Your online resource for accessing real-time plan information and more.

To access "Benefits Connection" go to: www.deltadentalnj.com and log onto "Benefits Connection." Once registered and logged in, you will be able to:

- ▶ Review your eligibility, claims history and status
- ▶ Browse our Oral Health Library
- ▶ Receive answers to your benefits-related questions
- ▶ Print ID cards
- ▶ Sign up for *Member News*, a free electronic monthly newsletter



Extensive Choice of Providers

Finding a Dentist. You can find a participating dentist two ways:

- ▶ **Website.** Using the Find a Dentist search feature at www.deltadentalnj.com.
- ▶ **Telephone.** Call toll free 1-800-DELTA-OK (1-800-335-8265) and a list of participating dentists located in your area can be emailed, faxed, or mailed directly to you.



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To learn more or to locate a provider near you visit www.deltadentalnj.com or call toll free 1-800-452-9310



Willingboro Public Schools

Where Excellence is the Expectation

DR. NEELY HACKETT

SUPERINTENDENT OF SCHOOLS

CHERELLE C. TOLOR, ESQ.

DIRECTOR OF HUMAN RESOURCES

COUNTRY CLUB ADMINISTRATION BUILDING

440 BEVERLY-RANCOGAS ROAD

TELEPHONE: (609) 835-8600 EXT. 1004

FAX: (609) 835-3841

TO: Full-Time Employees and Eligible Family Members

SUBJECT: Notification of Health Benefits Rights Under Federal Law

This letter provides information about health benefits that federal and State law requires your employer to send to you and your family members enrolled under State Health Benefits Program (SHBP) or School Employees' Health Benefits Program (SEHBP) coverage. Everyone enrolled under your coverage should read this information.

You should keep this letter and the enclosed information for future reference.

The first enclosure (the initial notification marked "Important Notice" and a copy of the COBRA – Continuation of Health Benefits Fact Sheet) details your rights under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA allows you or your covered dependents to extend health benefit coverage under the SHBP or SEHBP employee group in certain cases where you would otherwise lose that coverage.

The second enclosure (Notice to Health Benefits Program Participants about Compliance with Federal Health Insurance Requirements) contains information about special coverage provisions under federal law. The law establishes certain coverage requirements applicable to most employer health insurance plans. Certain plans, such as those in the SHBP or SEHBP, may exempt themselves from some of these requirements as long as participants of the plan are notified of the exemption. See the second enclosure for details about the SHBP/SEHBP's compliance with the health insurance coverage required by these federal laws.

The third enclosure (Notice of Privacy Practices to Enrollees in the SHBP/SEHBP) addresses privacy requirements under the Health Insurance Portability and Accountability Act (HIPAA) and how the SHBP/SEHBP may use and/or allow access to your personal health information.

The fourth enclosure (Medicaid and Children's Health Insurance Programs) provides information about premium assistance available to individuals for employer-sponsored health coverage.

The fifth enclosure (the Health Benefits Coverage of Children until Age 31 under Chapter 375 Fact Sheet) provides information about the coverage available to over age children who lose health benefit coverage prior to turning age 31.

There is nothing that you or your family members have to do as a result of this mailing. The sole purpose is to inform you of your rights under these federal and State laws and, by doing so, comply with the notification requirements contained in the laws. If you have any questions concerning this mailing, you should contact (employer human resource/benefits manager contact information) or the New Jersey Division of Pensions & Benefits' Office of Client Services at (609) 292-7524.

INFORMATION ON THE CONTINUATION OF GROUP HEALTH INSURANCE COVERAGE FOR NEW EMPLOYEES AND DEPENDENTS UNDER THE PROVISIONS OF COBRA

IMPORTANT NOTICE

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) OF 1985

Dear Employee and Family Members:

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 contains a provision pertaining to the continuation of health care benefits for persons enrolled for coverage through an employer group plan. COBRA requires that most employers sponsoring group health plans offer employees and their families who are losing coverage under the employer's plan the opportunity for a temporary extension of health coverage. This coverage, called continuation coverage, would be offered at group rates plus a small administrative fee, in certain instances where coverage under the plan would otherwise end.

This notice is intended to inform you of the rights and obligations under the continuation coverage provisions of the COBRA law should you ever lose the group health coverage provided through the New Jersey State Health Benefits Program (SHBP) or School Employees' Health Benefits Program (SEHBP).

This notice includes:

- COBRA Highlights
- Special Notices Concerning COBRA
- The *COBRA - Continuation of Health Benefits* Fact Sheet

Please take the time to read this notice carefully. Specific action must be taken by the employer, the employee, and covered family members to ensure the continuity of benefits under COBRA.

COBRA HIGHLIGHTS

EMPLOYER REQUIREMENTS

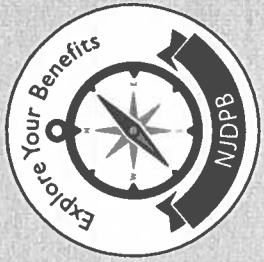
- Notify all newly hired employees and their dependents, within 90 days of when they are first enrolled in the SHBP or SEHBP, of the COBRA provisions by mailing a copy of the notification letter to their home.
- Notify the employee, spouse, civil union or domestic partner, and/or dependents of their rights to purchase continued health coverage within 14 days of receiving notice that there has been a COBRA-qualifying event. An application form and rate chart should be made available with the *COBRA Notice* that gives the date of termination of coverage and the period of time over which coverage may be extended. The notification must be mailed to the employee and family at the home address on file and a record of this notification should be maintained.

EMPLOYEE REQUIREMENTS

- The employee must notify the employer of a COBRA-qualifying event such as divorce, legal separation, termination of a civil union or domestic partnership, or dependent child ceasing to be eligible for coverage. This must be done within 60 days of the qualifying event.
- The employee or qualified beneficiary must notify the Health Benefits Bureau of the New Jersey Division of Pensions & Benefits of their decision to elect continued coverage by filing a *COBRA Application* and submitting required premiums within 60 days of employer notification.

SPECIAL NOTICES CONCERNING COBRA

1. If coverage under the plan is modified for group employees, the coverage will also be modified in the same manner for all COBRA eligible individuals electing continuation coverage.
2. If a second qualifying event occurs during the 18-month period following the date of employee's termination or reduction in hours, the beneficiary of that second qualifying event will be entitled to 36 months of continuation coverage. The period, however, will be measured from the date of the first qualifying event. **Example:** *John Smith terminates employment and enrolls in COBRA with husband and wife coverage for an 18-month term. In the tenth month, he dies. Mrs. Smith is now eligible to continue her coverage for a total of 36 months from the first COBRA event, leaving her 26 months of remaining eligibility.*
3. COBRA continuation will terminate on the date that the enrollee first becomes covered under any other group health plan as an employee or dependent.
4. If the health plan being continued offers a choice among types of coverage, employee, spouse/partner, and dependents are each entitled to make their own decision as to these choices.
5. If the employee or spouse/partner declines coverage, the spouse/partner and/or dependents may elect it for themselves.
6. COBRA subscribers are permitted to add dependents to their existing coverage within 60 days of their acquiring those dependents (i.e., marriage, entering a domestic partnership, birth, adoption, guardianship).
7. 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 health plan and, if offered by your employer, the Employee Dental Plans or Employee Prescription Drug Plan coverage during the Program's Open Enrollment period regardless of whether you elected to enroll for the coverage when you first enrolled in COBRA. However, the addition of a benefit during the Open Enrollment does not extend the maximum COBRA coverage period. All COBRA enrollees receive Open Enrollment information mailed directly to the address on file with the Program.
8. In order to protect you and your family's rights, you should keep your employer and the NJDPB informed of any changes in your address and the address(es) of your family members



COBRA — The Continuation of Health Benefits

Information for:
State Health Benefits Program (SHBP)
School Employees' Health Benefits Program (SEHBP)

INTRODUCTION

The federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that most employers sponsoring group health plans offer employees and their eligible dependents — also known under COBRA as qualified beneficiaries — the opportunity to temporarily extend their group health coverage in certain instances where coverage under the plan would otherwise end. For State Health Benefits' Program (SHBP) and School Employees' Health Benefits Program (SEHBP) participants, COBRA is not a separate health program; it is a continuation of SHBP or SEHBP coverage under the provisions of the federal law.

Note: Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) during what is called a Special Enrollment Period. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at: www.healthcare.gov

ELIGIBILITY FOR COBRA

Employees enrolled in the SHBP or SEHBP may continue coverage under COBRA, in any plan for which the employee is eligible, if coverage ends because of:

- Reduction in working hours;
- Leave of absence; or
- Termination of employment for reasons other than gross misconduct.

Note: Employees who at retirement are eligible to enroll in SHBP or SEHBP Retired Group coverage cannot enroll for health benefit coverage under COBRA.

Spouses, civil union partners, same-sex domestic partners,* or children under the age of 26 enrolled in the SHBP or SEHBP may continue coverage under COBRA, in any plan for which the employee is eligible, if coverage ends because of:

- Death of the employee;
- End of the employee's coverage due to a reduction in working hours, leave of absence, or termination of employment for reasons other than gross misconduct;
- Divorce or legal separation of the employee and spouse;
- Dissolution of a civil union or domestic partnership; or
- Election of Medicare as the employee's primary insurance carrier (requires dropping the group coverage carried as an active employee).

Note: Each qualified beneficiary may independently elect COBRA coverage to continue in any or all of the coverage you had as an active employee or dependent (medical, prescription drug, dental, and/or vision). You and/or your dependents may change your medical and/or dental plan when you enroll in COBRA. You may also elect to cover the same dependents you had as an active employee, or you can delete dependents to reduce your level of coverage. However, you cannot increase the level of your coverage, except during the annual Open Enrollment period, unless a qualifying event occurs (e.g., birth, adoption, marriage, civil union, domestic partnership) and you notify the New Jersey Division of Pensions & Benefits (NJDPB) COBRA Administrator within 60 days of the qualifying event.

*For more information about health benefits for civil union or domestic partners, including eligibility requirements, see the Civil Unions and Domestic Partnerships Fact Sheet.

DURATION OF COBRA COVERAGE

The length of your COBRA coverage continuation depends on the nature of the COBRA-qualifying event that entitled you to the coverage.

- For loss of coverage due to termination of employment, reduction of hours, or leave of absence, the employee and/or dependents are entitled to 18 months of COBRA coverage. Time on a leave of absence just before enrollment in COBRA, unless under the federal and/or State Family Leave Act, counts toward the 18-month period and will be subtracted from the 18 months. Time a member spends on federal or State leave will not count as part of the COBRA eligibility period.
- If you receive a Social Security Disability determination for an illness or injury you had when you enrolled in COBRA or incurred within 60 days of enrollment, you and your covered dependents are entitled to an extra 11 months of COBRA coverage (up to a maximum of 29 months). You must provide proof within 60 days of the disability determination from the Social Security Administration or within 60 days of COBRA enrollment.
- For loss of coverage due to the death of the employee, divorce or legal separation, dissolution of a civil union or domestic partnership, other dependent ineligibility, or Medicare entitlement, the continuation term for dependents is 36 months.

COST OF COVERAGE

You are responsible for paying the cost of your coverage under COBRA, which is the full group rate plus a two percent administrative fee. The NJDPB will bill you on a monthly basis.

EMPLOYEE / QUALIFIED BENEFICIARY RESPONSIBILITIES UNDER COBRA

The law requires that employees and/or their dependents:

- Keep the employer and the NJDPB informed of any changes to the address information of all possible qualified beneficiaries;
- Notify the employer that a divorce, legal separation, dissolution of a civil union or domestic partnership, or the death of the employee has occurred — notification must be given within 60 days of the date the event occurred. If you do not inform your employer of the change in dependent status within the 60-day requirement, you may forfeit your dependent's right to COBRA;
- File a *COBRA Application* within 60 days of the loss of coverage or the date of the *COBRA Notice* provided by the employer, whichever is later;
- Pay the required monthly premiums in a timely manner;
- Pay premiums, when billed, retroactive to the date of group coverage termination;
- Notify the NJDPB COBRA administrator, in writing, of any second qualifying event that results in an extension of the maximum coverage period. See the "Duration of COBRA Coverage" section; and
- Provide notice of any determination that a qualified beneficiary who had received a disability extension is no longer disabled. This notice must be sent to the NJDPB COBRA Administrator within 30 days of determination by the Social Security Administration. Failure to provide timely notification may result in adjustments to any claims paid erroneously.

EMPLOYER RESPONSIBILITIES UNDER COBRA

The COBRA law requires employers to:

- Notify employees and their dependents of the COBRA provisions within 90 days of when the employee/dependents are first enrolled in the SHBP or SEHBP by mailing a notification letter to the home address;
- Send the *COBRA Notice* and a *COBRA Application* within 14 days of receiving notice that a COBRA-qualifying event has occurred. The notice outlines the right to purchase continued health coverage, gives the date coverage will end, and the period of time over which coverage may be extended;
- Notify the NJDPB within 30 days of the date of an employee's/dependent's qualifying event or loss of coverage. An employee's loss of coverage is reported by completing a *Transmittal of Deletions Sheet*. A dependent's loss of coverage is reported through the NJDPB's receipt of a completed *Health Benefits Enrollment and/or Change Form* terminating the dependent's coverage; and
- Maintain records documenting their compliance with the COBRA law.

ENROLLING IN COBRA COVERAGE

The employee and/or the dependent seeking coverage is responsible for submitting a *COBRA Application* to the Health Benefits Bureau of the NJDPB. This application must be filed within 60 days of the loss of coverage or of the date of employer notification, whichever is later. Failure to submit the application within the time frame allowed by law is considered a decision not to enroll.

If you are retiring, you may be eligible for lifetime health, prescription drug, and dental coverage through the Retired Group of the SHBP or SEHBP. If you are eligible for Retired Group coverage, you are not eligible to continue coverage under COBRA. Consult your employer or the NJDPB prior to your retirement date.

FAILURE TO ELECT COBRA COVERAGE

In considering whether to elect continuation of coverage under COBRA, a qualified beneficiary should take into account that a failure to continue group health coverage will affect future rights under federal law.

You have the right under federal law to request special enrollment in another group health plan for which you are otherwise eligible, such as a plan sponsored by your spouse's/partner'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 provided the continuation of coverage under COBRA is for the maximum time available to you.

AFTER YOU HAVE ENROLLED IN COBRA

You should be aware of the following information after you have enrolled in COBRA:

- Bills will be sent from the NJDPB Health Benefits Bureau. Any billing questions must be referred to the:

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

or you may call the NJDPB Office of Client Services at (609) 292-7524.

- You will be billed monthly. Accounts delinquent

over 45 days will be closed and insurance coverage terminated retroactively to the date of last payment, or to the end of the month in which claims were submitted. If you do not receive a monthly bill or misplace it, contact the Office of Client Services. It is your responsibility to make payment on a timely basis.

- Once you are enrolled in COBRA, claims are handled just like active employee claims (i.e., using the same claim forms and procedures). However, you must indicate your status as a COBRA participant on all claim forms; this will help prevent claim processing issues. All COBRA premiums must be paid through the date of the claim in order for the claim to be processed. Questions about claims should be directed to the insurance carriers. The single exception is that vision plan claims are sent directly to the COBRA Administrator at the address previously shown.
- Plan administration under COBRA follows the same rules as for active employees. However, all activity is processed through the COBRA Administrator rather than the former employer. COBRA subscribers are permitted to change medical and/or dental plans and/or add coverage during the annual Open Enrollment period through the COBRA Administrator. All COBRA enrollees will receive Open Enrollment information mailed directly to their address on file with the SHBP or SEHBP.
- All changes in coverage due to a qualifying event must be made in writing to the COBRA Administrator at the address previously provided. Upon receipt of your letter, you will be sent a *COBRA Application*. To increase coverage, you have 60 days from the date of the qualifying event to make the change.

- To change plans because you have moved out of your plan's service area, you have 30 days to make the change.

- These changes must be requested within the specified time frames, otherwise they may only be made during the Open Enrollment period. You may decrease your coverage (delete a dependent) at any time, but not retroactively.

TERMINATION OF COBRA COVERAGE

Your COBRA benefits under the SHBP or SEHBP will terminate for any of the following reasons:

- Your employer (or former employer) no longer provides SHBP or SEHBP coverage to any of their employees. In this case, your employer will give you the opportunity to continue COBRA coverage through their new insurance plan for the balance of your COBRA continuation period;
- You become eligible for Medicare after you elect COBRA coverage (affects medical insurance coverage only; does not affect dental, prescription drug, or vision care coverage);
- You voluntarily cancel your coverage;
- You fail to pay your premiums; or
- Your eligible coverage continuation period ends.

CONVERSION OF COBRA COVERAGE

The COBRA law provides that you must be allowed to convert your coverage to an individual, non-group policy of the same health plan provided under the SHBP or SEHBP at the end of your COBRA enrollment period. You must complete your full coverage continuation period. Contact the health plan for details.

Note: There are no conversion provisions for prescription drug or dental coverage.

A NOTE ABOUT COVERAGE FOR CHILDREN AGE 26 UNTIL AGE 31

The NJDPB has specific guidelines about providing health coverage to children past the age of 26 until age 31 due to the enactment of P.L. 2005, c. 375 (Chapter 375). A child who attains age 26 and needs continued coverage can select either COBRA coverage or Chapter 375 coverage for medical benefits. Rates for COBRA coverage and Chapter 375 coverage can change annually; be sure to compare the rates prior to enrolling in either program.

Note: If the child opts to enroll in Chapter 375, he/she will not be permitted to enroll in COBRA once enrollment in Chapter 375 terminates.

Chapter 375 does not cover vision or dental benefits. If your child wishes to obtain those coverages, he/she must apply for them under COBRA.

The eligibility requirements for Chapter 375 are outlined in the *Health Benefits Coverage of Children Under Age 31 Under Chapter 375* Fact Sheet, which is available on our website.

MORE INFORMATION

If you need additional information about COBRA, see your human resources representative or benefits administrator, contact NJDPB Office of Client Services at (609) 292-7524, or send an email to: pensions.nj@treas.nj.gov

This fact sheet has been produced and distributed by:

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

(609) 292-7524

For the hearing impaired: TRS 711 (609) 292-6683
www.nj.gov/treasury/pensions

Notice to Health Benefits Program Participants about Compliance with Federal Health Insurance Requirements

This notice is being provided to inform you about State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) conformance with federal health insurance regulations.

Group health plans sponsored by State and local governmental employers, like the SHBP and SEHBP, must generally comply with federal law requirements in title XXVII of the Public Health Service Act to implement the following provisions that are contained in federal law:

1. Offer a special enrollment period to employees and dependents who do not enroll in the plan when initially eligible because they have other coverage, and who subsequently lose that coverage;
2. Provide a minimum level of hospital coverage for newborns and mothers, generally 48 hours for a vaginal delivery and 96 hours for a cesarean delivery;
3. Provide certain benefits for breast reconstruction after a mastectomy;
4. Continued coverage for up to one year for a dependent child who is covered as a dependent under the plan solely based on student status, who takes a medically necessary leave of absence from a postsecondary educational institution;
5. Provide parity in mental health benefits, that is, any dollar limitations applied to mental health treatment cannot be lower than those on medical and surgical benefits.

All SHBP and SEHBP plans will meet or exceed all federal requirements for 2021.

NOTICE OF PRIVACY PRACTICES TO ENROLLEES IN THE STATE HEALTH BENEFITS PROGRAM (SHBP) AND THE SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM (SEHBP)

**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: JANUARY 1, 2021**

Protected Health Information

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

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

Uses and Disclosures of PHI

The Programs are permitted to use and to disclose PHI in order for our members to obtain payment for health care services and to conduct the administrative activities needed to run the Programs without specific member authorization. Under limited circumstances, we may be able to provide PHI for the health care operations of providers and health plans. Specific examples of the ways in which PHI may be used and disclosed

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

- The Programs may disclose PHI to a doctor or a hospital to assist them in providing a member with treatment.
- The Programs may use and disclose member PHI so that our Business Associates may pay claims from doctors, hospitals, and other providers.
- The Programs receive PHI from employers, including the member's name, address, Social Security number, and birth date. This enrollment information is provided to our Business Associates so that they may provide coverage for health care benefits to eligible members.
- The Programs and/or our Business Associates may use and disclose PHI to investigate a complaint or process an appeal by a member.
- The Programs may provide PHI to a provider, a health care facility, or a health plan that is not our Business Associate that contacts us with questions regarding the member's health care coverage.
- The Programs may use PHI to bill the member for the appropriate premiums and reconcile billings we receive from our Business Associates.
- The Programs may use and disclose PHI for fraud and abuse detection.
- The Programs may allow use of PHI by our Business Associates to identify and contact

our members for activities relating to improving health or reducing health care costs, such as information about disease management programs or about health-related benefits and services or about treatment alternatives that may be of interest to them.

- In the event that a member is involved in a lawsuit or other judicial proceeding, the Programs may use and disclose PHI in response to a court or administrative order as provided by law.
- The Programs may use or disclose PHI to help evaluate the performance of our health plans. Any such disclosure would include restrictions for any other use of the information other than for the intended purpose.
- The Programs may use PHI in order to conduct an analysis of our claims data. This information may be shared with internal departments such as auditing or it may be shared with our Business Associates, such as our actuaries.

Except as described above, unless a member specifically authorizes us to do so, the Programs will provide access to PHI only to the member, the member's authorized representative, and those organizations who need the information to aid the Programs in the conduct of its business (our "Business Associates"). An authorization form may be obtained on our website: www.nj.gov/treasury/pensions or by sending an email to: hipaform@treas.nj.gov. A member may revoke an authorization at any time.

Restricted Uses

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

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

Member Rights

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

Right to Inspect and Copy: With limited exceptions, members have the right to inspect and/or obtain a copy of their PHI that the Programs maintain in a designated record set which consists of all documentation relating to member enrollment and the Programs' use of this PHI for claims resolution. The member must make a request in writing to obtain access to their PHI. The member may use the contact information found at the end of this Notice to obtain a form to request access.

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

We cannot amend demographic information, treatment records or any other information created by others. If members would like to amend any of their demographic information, 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 Programs may deny the member's request if: 1) we did not create the information requested on the amendment; 2) the information is not part of the designated record set maintained by the Programs; 3) the member does not have access rights to the information; or 4) we believe the information is accurate and complete. If we deny the member's request, we will provide a written explanation for the denial and the member's rights regarding the denial.

Right to an Accounting of Disclosures: Members have the right to receive an accounting of the instances in which the Programs or our Business Associates have disclosed member PHI. The accounting will review disclosures made over the past six years. We will provide the member with the date on which we made a disclosure, the name of the person or entity to whom we disclosed the PHI, a description of the information we disclosed, the reason for the disclosure, and certain other information. Certain disclosures are exempted from this requirement (e.g., those

made for treatment, payment or health benefits operation purposes or made in accordance with an authorization) and will not appear on the accounting.

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

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

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

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

To request changes to confidential communications, the member must make their request in writing, and must clearly state that the information could

endanger them if it is not communicated in confidence as they requested.

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

Questions and Concerns

If you have questions or concerns, please contact the Programs using the information listed at the end of this Notice.

If members think the Programs may have violated their privacy rights, or they disagree with a decision made about access to their PHI, in response to a request made to amend or restrict the use or disclosure of their information, or to have the Programs communicate with them in confidence by alternative means or at an alternative location, they must submit their 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 concern to the U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Washington, DC 20201.

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

Contact Office: HIPAA Privacy Officer

Address:

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

Fax: (609) 341-3412

Email: hipaaform@treas.nj.gov

Notice of Availability

SHBP/SEHBP Notice of Privacy Practices

This notice describes how you may obtain a copy of the plan's *Notice of Privacy Practices*, which describes the ways that the plan uses and discloses your Protected Health Information (PHI).

The SHBP and SEHBP (the "Plan") provide health benefits to eligible employees and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains, and discloses health information about participating employees and dependents in the course of providing these health benefits.

The Plan is required by law to provide notice to participants of the Plan's duties and privacy practices with respect to covered PHI and has done so by providing to Plan participants a *Notice of Privacy Practices*, which describes the ways that the Plan uses and discloses PHI.

The Plan's *Notice of Privacy Practices* is available at the New Jersey Division of Pensions & Benefits website: **www.nj.gov/treasury/pensions**

If you have any questions about the Plan's privacy practices, please contact your human resources office.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid		CALIFORNIA – Medicaid	
Website: http://myalhipp.com/ Phone: 1-855-692-5447		Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676	
ALASKA – Medicaid		COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx		Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442	
ARKANSAS – Medicaid		FLORIDA – Medicaid	
Website: http://myarhipp.com/ Phone: 1-855-MyARHIP (855-692-7447)		Website: https://www.flmedicaidtplecovery.com/flmedicaidtplecovery.com/hipp/index.html Phone: 1-877-357-3268	

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
INDIANA – Medicaid	MINNESOTA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	MISSOURI – Medicaid
Medicaid Website: https://dhs.iowa.gov/imc/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	MONTANA – Medicaid
Website: http://www.kdhecks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY – Medicaid	NEBRASKA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kidshhealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	NEVADA – Medicaid
Website: www.medicicaid.la.gov or www.ldh.la.gov/la hipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	NEW HAMPSHIRE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/oi/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP		SOUTH DAKOTA - Medicaid	
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710		Website: http://dss.sd.gov Phone: 1-888-828-0059	
NEW YORK – Medicaid		TEXAS – Medicaid	
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831		Website: http://gethipptexas.com/ Phone: 1-800-440-0493	
NORTH CAROLINA – Medicaid		UTAH – Medicaid and CHIP	
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100		Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	
NORTH DAKOTA – Medicaid		VERMONT– Medicaid	
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825		Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	
OKLAHOMA – Medicaid and CHIP		VIRGINIA – Medicaid and CHIP	
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742		Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282	
OREGON – Medicaid		WASHINGTON – Medicaid	
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075		Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	
PENNSYLVANIA – Medicaid		WEST VIRGINIA – Medicaid	
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462		Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	
RHODE ISLAND – Medicaid and CHIP		WISCONSIN–Medicaid and CHIP	
Website: http://www.cohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RItE Share Line)		Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	
SOUTH CAROLINA – Medicaid		WYOMING – Medicaid	
Website: https://www.scdhhs.gov Phone: 1-888-549-0820		Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269	

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

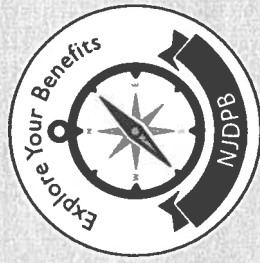
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebbsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)



Health Benefits Coverage of Children Until Age 31 Under Chapter 375

Information for:
State Health Benefits Program (SHBP)
School Employees' Health Benefits Program (SEHBP)

ELIGIBILITY

Under the State Health Benefits Program (SHBP) or the School Employees' Health Benefits Program (SEHBP), an eligible child is defined as a subscriber's child under age 26. Health benefits coverage for children usually ends as of December 31 of the year in which the child turns age 26.

Under the provisions of P.L. 2005, c. 375 (Chapter 375), as amended by P.L. 2008, c. 38 (Chapter 38), certain over age children may be eligible for coverage until age 31.

This includes a child by blood or law who:

- Is under the age of 31;
- Is unmarried;
- Has no dependent(s) of his or her own;
- Is a resident of New Jersey or is a full-time student at an accredited public or private institution of higher education; and
- Is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare.

ENROLLMENT

A covered employee from a SHBP- or SEHBP-participating employer or retiree may enroll an over age child who is Chapter 375-eligible at either of the following times:

- If, within 60 days of coverage loss for the child, the covered employee or retiree provides proof of loss of other group coverage (HIPAA certificate). If the termination was due to the child attaining age 26 within the SHBP/SEHBP, proof of coverage loss is not required; coverage will be effective the date that the prior coverage was terminated; or
- During the Open Enrollment period of each year (October) if the over age child meets the eligibility requirements of Chapter 375 as outlined previously. Coverage will be effective the following January 1.

REQUIRED DOCUMENTATION

A completed *Chapter 375 Application*, a photocopy of the over age child's birth certificate, and a photocopy of the front page of the child's most recently filed federal tax return (*Form 1040*) are required. You may black out all financial information and all but the last four digits of any Social Security numbers.

If the child resides outside of the State of New Jersey, documentation of full-time student status must be submitted.

If applicable, proof of loss of other coverage (HIPAA certificate) is also required when enrolling for this extended coverage. If the over age child is adopted, a stepchild, or a legal ward, supporting documentation is required if not already on file. For a description of the required documentation, see the New Jersey Di-

vision of Pensions & Benefits (NJDPB) website at: www.nj.gov/treasury/pensions

PLAN SELECTION

Under Chapter 375, an over age child does not have any choice in the selection of benefits, but is enrolled in exactly the same plan or plans (medical and/or prescription drug) that the covered parent has selected. There is no provision for dental or vision benefits. See the "A Note About COBRA Coverage" section.

COVERAGE COSTS

When Chapter 375 coverage is elected, the covered parent will be billed directly for the cost; therefore, the covered parent is held responsible for the payment of the coverage.

Chapter 375 Rate Charts showing the premium amounts for all health benefit plans are available on our website.

Enrollment of over age children for coverage under Chapter 375 is voluntary. The provisions of Chapter 375 do not require an employer to pay any part of the cost of this coverage.

WHEN COVERAGE ENDS

Coverage for an enrolled over age child will end when the child no longer meets any one of the eligibility requirements previously listed or when the covered parent's coverage ends (e.g., termination of employment, divorce, or death of the covered parent). Coverage may also be terminated in the event of non-payment of the required premiums.

Chapter 375 coverage ends on the first of the month following the event that makes the child ineligible. Coverage will be terminated in accordance with N.J.S.A. 52:14-17.29k if premiums are not received within 45 days of the payment due date. If the coverage was used and the premium(s) was not paid, the parent and Chapter 375 subscriber will be responsible for the additional monthly premiums. To terminate coverage, complete a *Chapter 375 Application*. A letter signed by the covered parent is also acceptable.

Note: Written requests on the bill for termination will not be accepted.

The termination date is dependent upon the following:

- Date of acceptable request to terminate;
- Date of service of last paid claim; and/or
- Non-payment of premiums.

Terminations will not be retroactive unless the request is received within 30 days of the requested termination date and no claims have been paid for services after that date. Otherwise, the coverage will be terminated timely.

COVERAGE UNDER THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

The year in which your covered child turns age 26, you will receive a COBRA notification letter prior to the termination of the child's coverage, which is required by federal law. The notice outlines the right to purchase continued health coverage, gives the date coverage will end, and the period of time over which coverage may be extended (usually 36 months). Rates for Chapter 375 coverage and COBRA coverage can change annually; be sure to compare the rates prior to enrolling in either program.

There is no provision for the continuation of group coverage under COBRA for a child due to the loss of Chapter 375 coverage, nor is there any provision for conversion to non-group coverage.

Since Chapter 375 does not cover vision and dental benefits, your child may request to obtain them under COBRA.

ADDITIONAL INFORMATION

For a *Chapter 375 Rate Chart*, a *Chapter 375 Application*, or if you have additional questions, see your employer's benefits administrator, or the Chapter 375 information on the NJDPB website.

If you need information concerning COBRA coverage, see the *COBRA — The Continuation of Health Benefits* Fact Sheet.

You may also contact the NJDPB Office of Client Services at (609) 292-7524, or email the NJDPB at pensions.nj@treas.nj.gov

Note: Instead of enrolling in Chapter 375 coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through a Special Enrollment Period. Some of these options may cost less than Chapter 375 coverage. You can learn more about many of these options at: www.healthcare.gov

This fact sheet has been produced and distributed by:

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