ANNUAL OPEN ENROLLMENT

2017-2018
Bergen County Technical Schools/ Special Services
Benefits Notices

2017-2018 Open Enrollment Benefit Notices

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NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Gary P. Hall, Coordinator of Human Resources, 201-343-6000 ext. 6062.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____.

SEHBP Horizon Member Services: 1-800-414-SHBP (1-800-414-7427); Aetna Member Services: 1-877-STATE NJ (1-877-782-8365)

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Bergen County Technical Schools/Special Services	4. Employer Identification Number (EIN) 22-6002432	
5. Employer address 540 Farview Avenue	6. Employer phone number 201-343-6000	
7. City Paramus	8. State NJ	9. ZIP code 07652
10. Who can we contact about employee health coverage at this job? Gary P. Hall		
11. Phone number (if different from above) 201-343-6000 ext 6062 ☐	12. Email address garhal@bergen.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  □All employees. Eligible employees are:

  [X] Some employees. Eligible employees are:
  Full-Time employees working 25+ hours per week

- With respect to dependents:

  [X] We do offer coverage. Eligible dependents are:
  Spouse
  Children

  □ We do not offer coverage.

[X] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

NOTICE REGARDING WELLNESS PROGRAM

NJWELL is an employee wellness program designed to help actively employed members of the State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) live a healthy lifestyle. The SHBP and SEHBP hope to increase overall wellness and reward eligible employees and their covered spouses or partners for completing activities designed to promote healthy behaviors. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for Cholesterol, Triglycerides, Glucose (sugar) and Body Mass Index or BMI (based on height & weight). You will also have your pulse and blood pressure measured during the screening. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive ranging from $125 to $250. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives may be available for employees who participate in certain health-related activities such as participating in online coaching, online activities, to name a few.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such coaching. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and State Health Benefits Plan/School Employees Health Benefits Plan may use aggregate information it collects to design a program based on identified health risks in the workplace, NJWELL will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no

information you provide as part of the wellness program will be used in making any employment decision.

Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact NJ Division of Pensions and Benefits Office of Client Services at 609-292-7524 or www.nj.gov/NJWELL

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICES

Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator NJ Division of Pensions and Benefits Office of Client Services at 609-292-7524.

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at NJ Division of Pensions and Benefits Office of Client Services at 609-292-7524 for more information.

EMPLOYER CHIP NOTICE

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, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
ALASKA – Medicaid	**INDIANA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507

FLORIDA – Medicaid

Website: http://flmedicaidtplrecovery.com/hipp/

Phone: 1-877-357-3268

IOWA – Medicaid

Website: http://www.dhs.state.ia.us/hipp/

Phone: 1-888-346-9562

LOUISIANA – Medicaid

Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331

Phone: 1-888-695-2447

KENTUCKY – Medicaid

Website: http://chfs.ky.gov/dms/default.htm

Phone: 1-800-635-2570

MAINE – Medicaid

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html

Phone: 1-800-442-6003

TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: http://www.mass.gov/eohhs/gov/departments/masshealth

Phone: 1-800-462-1120

MINNESOTA – Medicaid

Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs-and-services/medical-assistance.jsp

Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm

Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP

Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: http://ACCESSNebraska.ne.gov

Phone: 1-855-632-7633; Lincoln: 1-402-473-7000

Omaha: 1-402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dwss.nv.gov/

Medicaid Phone: 1-800-992-0900

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/

Phone: 1-785-296-3512

NEW HAMPSHIRE – Medicaid

Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf

Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP

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

NEW YORK – Medicaid

Website: http://www.nyhealth.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: http://www.ncdhhs.gov/dma

Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/

Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org

Phone: 1-888-365-3742

OREGON – Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html

Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website:
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthipprogram/index.htm

Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: http://www.eohhs.ri.gov/

Phone: 855-697-4347

SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA – Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT – Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

MEDICARE PART D CREDITABLE COVERAGE NOTICE

Important Notice from Bergen Technical Schools /Special Services **About Your Prescription Drug Coverage and Medicare**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Bergen Technical Schools /Special Services **and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.**

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. Bergen Technical Schools /Special Services **has determined that the prescription drug coverage offered by** Maxor Plus **is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current **Bergen Technical Schools /Special Services** coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current **Bergen Technical Schools /Special Services** coverage, be aware that you and your dependents will not be able to get this coverage back until the next open enrollment, possibly.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with **Bergen Technical Schools /Special Services** and don't join a Medicare drug plan within 63 continuous days after your current

coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through **Bergen Technical Schools /Special Services** changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	09/27/17
Name of Entity/Sender:	**Bergen Technical Schools /Special Services**
Contact--Position/Office:	Gary P. Hall
Address:	540 Farview Avenue, Paramus, NJ 07652
Phone Number:	201-343-6000 ext 6062

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

IMPORTANT NOTICE

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
- Fact Sheet #30, *Continuation of Health Benefits Insurance Under COBRA*

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 eligible 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 Division of Pensions and 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. As an 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 an eligible 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 Division of Pensions and Benefits informed of any changes in your address and the address(es) of your family members.

Continuation of Health Benefits Under COBRA

State Health Benefits Program • School Employees' Health Benefits Program

INTRODUCTION

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 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.

ELIGIBILITY FOR COBRA

Please 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) through 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*.

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

- 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, or eligible same-sex domestic partners* of employees enrolled in the SHBP or SEHBP may continue coverage under COBRA, in any plan that the employee is eligible for, if coverage ends because of the:

- 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).

**For more information about health benefits for domestic partners, including eligibility requirements, see Fact Sheet #71, Benefits Under the Domestic Partnership Act. For more information about health benefits for civil union partners see Fact Sheet #75, Civil Unions.*

Children under age 26 may continue coverage under COBRA if the following occurs:

- 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; 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 (birth, adoption, marriage, civil union, eligible domestic partnership) and you notify the Division of Pensions and Benefits' COBRA Administrator within 60 days of the qualifying event.

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 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 Administration 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 coverage up to a maximum of 29 months of COBRA coverage. 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 Division of Pensions and Benefits will bill you on a monthly basis.

EMPLOYEE / QUALIFIED BENEFICIARY RESPONSIBILITIES UNDER COBRA

The law requires that employees and/or their dependents:

- Keep your employer and the Division of Pensions and Benefits informed of any changes to the address information of all possible "qualified beneficiaries."

- Notify your employer that a divorce, legal separation, dissolution of a civil union or domestic partnership, or the death of the employee has occurred or that a covered child has reached age 26 — 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 your 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 Division of Pensions and Benefits' COBRA Administrator, in writing, of any second qualifying event that results in an extension of the maximum coverage period (see "Duration of COBRA Coverage" above);
- Notify the Division of Pensions and Benefits' COBRA Administrator, in writing, of a Social Security Administration disability award within 60 days of receipt of the award, or within 60 days of COBRA enrollment (this will extend the maximum COBRA coverage period from 18 months to 29 months — see "Duration of COBRA Coverage" above); 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 Division of Pensions and Benefits' 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 and their dependents are first enrolled in the SHBP or SEHBP by mailing a notification letter to their home;
- Notify employees, their spouse or partner, and their children of the right to purchase continued coverage within 14 days of receiving notice that there has been a COBRA qualifying event that causes a loss of coverage;
- Send the *COBRA Notification Letter* and a *COBRA Application* within 14 days of receiving notice that a COBRA qualifying event has occurred. 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 Division of Pensions and Benefits within *30 days* of the date of an employee/ 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 Division's receipt of a completed health benefit application terminating the dependent's coverage.)
- Maintain records documenting their compliance with the COBRA law.

ENROLLING FOR COBRA COVERAGE

The employee and/or the dependent seeking coverage is responsible for submitting a properly completed *COBRA Application* to the Health Benefits Bureau of the Division of Pensions and Benefits. 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.**

- In considering whether to elect continuation of coverage under COBRA, you should take into account that you cannot enroll at a later date and that a failure to continue your group health coverage may affect your future rights under federal law (see "Failure to Elect COBRA Coverage", on page 4).
- 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 Division of Pensions and Benefits 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 should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's/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 Division of Pensions and Benefits/Health Benefits Bureau. Any billing questions must be referred to the:

  COBRA Administrator
  Division of Pensions and Benefits
  Health Benefits Bureau
  PO Box 299
  Trenton, NJ 08625-0299

  or you may call the Division's 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 also 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 shown above.

- 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 (in the fall) 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" (for example: the birth of a child, a marriage, civil union, divorce, a death, etc.) 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 change form. 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.

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 its 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 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 enroll in 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.

MORE INFORMATION

If you need additional information about COBRA, see your Human Resources Representative or Benefits Administrator, or contact the Division of Pensions and Benefits Office of Client Services at (609) 292-7524, or send an e-mail to: *pensions.nj@treas.nj.gov*

A NOTE ABOUT COVERAGE FOR CHILDREN AGE 26 UNTIL AGE 31

The Division of Pensions and Benefits has specific guidelines about providing health coverage to children past the age of 26 until age 31 due to the enactment of Chapter 375, P.L. 2005. 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.

Please note that 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 Fact Sheet #74, *Health Benefit Coverage of Children Until Age 31 Under Chapter 375,* which is available on our Web site.

This fact sheet has been produced and distributed by:
New Jersey Division of Pensions and Benefits • PO Box 295 • Trenton, New Jersey 08625-0295
(609) 292-7524 • For the hearing impaired: TRS 711 (609) 292-6683
URL: http://www.nj.gov/treasury/pensions • E-mail: pensions.nj@treas.nj.gov

Are there other coverage options besides COBRA Continuation Coverage?

Yes. 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) through 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.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Gary P. Hall
Coordinator of Human Resources
201-343-6000 ext. 6062

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

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

EFFECTIVE DATE: JANUARY 1, 2017.

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 over the Internet at: *www.nj.gov/treasury/pensions*

or by sending an e-mail to: *hipaaform@treas.state.nj.us*. 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 Complaints

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 complaint 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: State of New Jersey
Department of the Treasury
Division of Pensions and Benefits
PO Box 295
Trenton, NJ 08625-0295

Fax: (609) 341-3412

E-mail: *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.

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 individuals' protected health information (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 Division of Pensions and Benefits Web site: *www.nj.gov/treasury/pensions/hipaa-notice.shtml*

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

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, SEHBP and local plans will meet or exceed all federal requirements for 2017 and 2018.

MICHELLE'S LAW NOTICE

Note: Pursuant to Michelle's Law, you are being provided with the following notice because the

Bergen County Technical Schools/Special Services *group health plan provides dependent coverage beyond age 26 and bases eligibility for such dependent coverage on student status. Please review the following information with respect to your dependent child's rights under the plan in the event student status is lost.*

When a dependent child loses student status for purposes of ***Bergen County Technical Schools/Special Services*** group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the ***Bergen County Technical Schools/Special Services*** group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the ***Bergen County Technical Schools/Special Services*** group health plan, whichever is earlier.

In order to be eligible to continue coverage as a dependent during such leave of absence:

- The ***Bergen County Technical Schools/Special Services*** group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary; and
- Must be enrolled in the plan immediately prior to the first day of the medically necessary leave of absence.

To obtain additional information, please contact:

Gary P. Hall
Coordinator of Human Resources
201-343-6000 ext. 6062.

A PUBLICATION O F THE NEW JERSEY DIVISION O F PENSIONS AND BENEFITS

HEALTH BENEFIT COVERAGE OF CHILDREN UNTIL AGE 31 UNDER CHAPTER 375, P.L. 2005

State Health Benefits Program • School Employees' Health Benefits Program

COVERAGE FOR CHILDREN

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.

CHAPTER 375 CHILDREN

Under the provisions of Chapter 375, P.L. 2005, as amended by Chapter 38, P.L. 2008, 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.

ENROLLING IN CHAPTER 375 COVERAGE

A covered employee (from a SHBP or SEHBP participating employer) or retiree may enroll an over age child who is Chapter 375 eligible and 30 years of age or younger at either of the following times:

- if, within 60 days of coverage loss, for the child, the covered employee 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 above. Coverage will be effective the following January 1.

REQUIRED DOCUMENTATION

A completed *Chapter 375 Application for Coverage,* 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, documentation of the 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 step child, or a legal ward, supporting documentation is required, if not already on file. For a description of the required documentation, see the Division of Pensions and Benefits Web site at: *www.nj.gov/treasury/pensions/health-benefits.shtml*

PLAN SELECTION

Under Chapter 375 an over age child does not have any choice in the selection of benefits, but is enrolled for coverage in exactly the same plan or plans (medical and/or prescription drug) that the covered parent has selected. There is no provision for eligibility for dental or vision benefits (see "A Note About COBRA Coverage" on page 3).

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 Chapter 375 coverage.

Chapter 375 Rate Charts showing the premium amounts for all health benefit plans are available from your employer, by contacting the Division of Pensions and Benefits, or over the Internet at: *www.nj.gov/treasury/pensions/health-benefits.shtml*

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 for any election 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 listed above, or when the covered parent's coverage ends (for example: 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 or the date 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 the *Chapter 375 Application* and check the box in section four. 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:

- Timeliness of receipt of written request;
- Date of service of last paid claim; and
- 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.

Fact Sheet #74

A NOTE ABOUT COBRA COVERAGE

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.

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

ADDITIONAL INFORMATION

For a *Chapter 375 Rate Chart*, a C*hapter 375 Application for Coverage,* or if you have additional questions about Chapter 375 eligibility or coverage, see your employer's Benefits Administrator, or the Chapter 375 information at the Division of Pensions and Benefits Web site at: *www.nj.gov/treasury/pensions/health-benefits.shtml*

If you need information concerning COBRA coverage, see Fact Sheet #30, *Continuation of Health Benefits Insurance Under COBRA,* available from your employer or the Web site listed above.

You may also contact the Division of Pensions and Benefits' Office of Client Services at (609) 292-7524, or e-mail the Division at: *pensions.nj@treas.nj.gov*

Please 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) through 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*

This fact sheet has been produced and distributed by:
New Jersey Division of Pensions and Benefits • PO Box 295 • Trenton, New Jersey 08625-0295
(609) 292-7524 • For the hearing impaired: TRS 711 (609) 292-6683
URL: http://www.nj.gov/treasury/pensions • E-mail: pensions.nj@treas.nj.gov

GENERAL FMLA NOTICE

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered service member's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the service member with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

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