



State of New Jersey
Department of Military and Veterans Affairs
P.O. Box 340
Trenton, NJ 08625-0340



24 October 2011

INTEROFFICE MEMORANDUM

TO: DMAVA State Employees

FROM: Loreta P. Sepulveda *LS*
Director, Human Resources Division

SUBJECT: Open Enrollment 2012 Important Changes

Open Enrollment for Health and Dental Benefits is now 10/17/11 - 11/11/11.
Open Enrollment for the State Employees Tax Savings Program (Tax\$ave) is extended and now ends November 11, 2011.

During the Open Enrollment period employees can make general changes (adding or deleting dependents, changing coverage levels, etc.) or enroll in a different medical or dental plan. **All changes to coverage made during this Open Enrollment period will be effective on December 31, 2011 with any required deductions taken beginning with pay period 1 (pay check of December 30, 2011).**

Completed health benefits and/or dental applications must arrive at your local HR office no later than November 11, 2011, to ensure processing for the start of the 2012 plan year.

NEW PLAN DESIGNS

On October 5, 2011, the State Health Benefits Plan Design Committee approved **new Medical and prescription drug plans** to be offered through the SHBP. The current NJ DIRECT15, Aetna HMO, and CIGNA HealthCare HMO plans will still be available through the SHBP in plan year 2012. However, additional plan options are now also available.

- Horizon Blue Cross Blue Shield of New Jersey (BCBSNJ), Aetna, and CIGNA will each offer **two additional plan design options**, which provide lower premiums in exchange for higher copayments, deductibles, and out-of-pocket amounts on services that are received.
- Horizon BCBSNJ, Aetna, and CIGNA will each also offer **High Deductible Health Plans** for employees and certain retirees.

- Under the active Employee Prescription Drug Plan the copayments will remain the same for the current plans; however, the new plan designs have different copayments. In addition, employees who choose a high deductible health plan cannot be enrolled in the active Employee Prescription Drug Plan. Instead, prescription drugs are covered under the plan and are subject to a deductible. Premium rate charts for the new plans are available on line in your local HR office.
- Employees may enroll in the new plans during the Open Enrollment period for coverage in the 2012 plan year. Plan rates were approved by the State Health Benefits Commission on October 12, 2011. Rate charts will be posted to the Division of Pensions and Benefits Website at:

www.state.nj.us/treasury/pensions as soon as they are available for release.
- Employees who are simply adding or deleting a dependent, or changing coverage levels should complete a *Health Benefits Application* and submit it to their local HR office any time during the Open Enrollment period.

EMPLOYEE CONTRIBUTIONS FOR SHBP COVERAGE

Pursuant to Chapter 78, P.L. 2011, the Pension and Health Benefit Reform Law, new employee health benefit contribution amounts became effective in October 2011.

Employees must pay either a percentage of the medical and prescription plan premium or 1.5% of their annual salary, whichever is greater. There will not be another Open Enrollment period before July 1, 2012.

Employees should be advised that if they are subject to the 4-year phase-in of Chapter 78 contribution rates, Year One contribution rates will apply for the period of January 1, 2012 through June 30, 2012 and Year Two contribution rates will apply for the period of July 1, 2012 through December 31, 2012.

WAIVING SHBP COVERAGE

State employees are permitted to waive SHBP medical *and* prescription coverage provided that they have other health care coverage. To waive coverage a *SHBP State Waiver* form and a *Health Benefit Application* must be completed and submitted by **November 11, 2011**. To waive coverage effective January 1st, employees should indicate "**Open Enrollment**" on the waiver form; otherwise, the waiver will be processed on a timely basis.

DENTAL PLANS AND EMPLOYEE COSTS

Dental coverage is offered to all eligible State employees through the **Employee Dental Plans**. Seven different dental plans are offered based on one of two different plan designs - **Dental Plan Organizations (DPO)** and a **Dental Expense Plan (PPO)**. Rate charts have been attached for your use.

Your local Human Resources Office will provide a presentation on the new health plans for all employees. Please watch for those sessions as they are scheduled locally.

Please remember Key Dates

10/17/11 -11/11/11	Open enrollment for Health and Dental Benefits
10/01/11 - 11/11/11	Open Enrollment for State Employees Tax Savings Program (Tax\$ave) is extended
11/11/11	All health and dental applications are due to your local HR for processing to Division of Pensions and Benefits

Attachments

Cf:

- (TAG) MG Glenn K. Rieth**
- (JCOS) BG James Grant**
- (DCVA) Raymond Zawacki**
- (HRD-PMRS) Cindy Leese**
- (HRD-ERO) Linda Randolph**

INSTRUCTIONS FOR THE HEALTH BENEFITS APPLICATION STATE ACTIVE EMPLOYEE GROUPS

- **To change your primary care physician (PCP)** with your HMO, contact your health plan directly. **DO NOT COMPLETE THIS FORM JUST TO CHANGE YOUR PRIMARY CARE PHYSICIAN.**
- **To enroll** for the first time, complete all sections of the application with the exception of section 5.
- **To change health plans only** complete sections: 1, 2a and 2b (if enrolling in an HMO be sure to list your primary care physician's identification number), 4 (listing all eligible dependents), and 6.
- **To change coverage level** (adding/deleting dependents) complete sections: 1, 2a and 2b, 3a and 3b (if Employee Prescription Drug Plan coverage is provided by your employer), 4 (list all eligible dependents), 5 (list why you are changing coverage level), and 6.
- **To add a dependent** complete sections: 1, 2a and 2b, 3a and 3b (if Employee Prescription Drug Plan coverage is provided by your employer), 4 (list all eligible dependents), 5a, and 6. You must also attach the required proof of dependency documents.
- **To terminate/decline coverage** complete sections: 1, 2a and/or 3a (as applicable), and 6. (If you are eligible to waive coverage under the provisions of N.J.S.A. 52:14-17.31(a), you must also complete and attach the *Waiver/Reinstatement Declaration* form available from your employer. Both Medical and, if applicable, Prescription Drug coverage must be waived to avoid paying the 1.5% contribution.) If you are declining enrollment for yourself or any or all of your eligible dependents because of other group health insurance coverage, you may in the future be able to enroll yourself and/or your eligible dependents in a SHBP or SEHBP medical plan, provided that you request enrollment within 60 days after other group health coverage ends.

SECTION 1 - EMPLOYEE INFORMATION

This section must be completed in its entirety each time an application is submitted. The employee enrolling or enrolled in the plan completes this section.

SECTION 2 - MEDICAL COVERAGE

- 2a. Check the box and indicate the medical plan you wish to be enrolled in. If you do not want medical coverage or wish to cancel coverage, check the box to waive coverage. Both Medical and Prescription Drug must be waived to avoid paying any contribution.
- 2b. If you are electing coverage, check the level of coverage desired.

SECTION 3 - PRESCRIPTION DRUG COVERAGE

The Employee Prescription Drug Plan is available to State employees:

- 3a. To enroll, check the box to indicate that you wish to be covered. If you do not want prescription drug coverage or wish to cancel coverage, check the box to waive coverage. Both Medical and Prescription Drug must be waived to avoid paying the 1.5% contribution.
- 3b. If you are electing coverage, check the level of coverage desired. (if enrolling a domestic partner, see eligibility information in "Domestic Partner" below).

NOTE: Once you decline or cancel Medical or Prescription Drug coverage, enrollment is not permissible until the next open enrollment period or if other coverage is lost and proof of loss is provided (HIPAA).

SECTION 4 - DEPENDENT INFORMATION

Only eligible dependents may be listed. Completion of this section is essential for proper enrollment. Be sure dependents listed agree with the level of coverage selected in sections 2b, and 3b. List the name, date of birth, gender, and Social Security number of the family members you wish to cover under the plan. You may list an eligible spouse, civil union partner, or same-sex domestic partner, or your child under age 26 (as defined below). If enrolling in an HMO, include each dependent's HMO Primary Care Physician identification number — all dependents must have this information listed. Refer to the HMO plan's provider directory or Web site for this information, or call the HMO plan directly. Plan Web sites and phone numbers can be found on the *Plan Comparison Summary*.

SPOUSE: This is a person of the opposite sex to whom you are legally married. A photocopy of the *Marriage Certificate* and a photocopy of the employee's most recent Federal tax return* that includes the spouse are required for enrollment.

CIVIL UNION PARTNER: This is a person of the same sex with whom you have entered into a civil union. A photocopy of the *New Jersey Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions and a photocopy of the employee's most recent NJ tax return* that includes the partner are required for enrollment. The cost of civil union partner coverage may be subject to federal tax (see your employer or Fact Sheet #75, *Civil Unions*, for details).

DOMESTIC PARTNER: This is a same-sex domestic partner, as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act, of any State employee, State retiree, or an eligible employee or retiree of a participating local public entity if the local governing body adopts a resolution to provide Chapter 246 health benefits. A photocopy of the *New Jersey Certificate of Domestic Partnership* dated prior to February 19, 2007 or a valid certification from another jurisdiction that recognizes same-sex domestic partners and a photocopy of the employee's most recent NJ tax return* that includes the partner are required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer or Fact Sheet #71, *Benefits Under the Domestic Partnership Act*, for details).

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

CHILDREN: This is your child under age 26. A photocopy of a child's birth certificate showing the name of the employee as a parent is required for enrollment. If you have listed a child who is an adopted child, foster child, stepchild, legal ward, has a different last name than the employee, or if the member has a Parent/Child contract, additional supporting documentation is required. A child is only eligible if he or she is not eligible to enroll in other employer-based coverage (aside from coverage through the parent). If you have more than four eligible dependent children, attach a separate application and complete Sections 1, 4, and 6.

NOTE: If you are deleting dependents, do not list them in this section. Refer to section 5b and 5c.

SECTION 5 - TYPE OF ACTIVITY

- 5a. If you are adding a dependent, check the appropriate box and indicate the event date.
- 5b. If you are deleting a dependent spouse, civil union partner, or domestic partner, check reason and indicate the event date.
- 5c. If you are deleting a dependent child, indicate the event date, list the child's Social Security number, and give reason.
- 5d. For other changes, check the appropriate box, give requested information, and attach a copy of supporting documentation if applicable.

SECTION 6 - EMPLOYEE CERTIFICATION

You must read the Employee Certification statement, **sign it, date the application, and attach any required proof for dependents.**

Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

EMPLOYER CERTIFICATION

Must be completed by your employer before submitting the application to the Health Benefits Bureau. By signing this application the employer certifies that:

- 1) The employee is eligible;
- 2) The application is legible and completed in its entirety;
- 3) The employee's selected plans and coverage levels are appropriate;
- 4) The Employer Certification section is completed in its entirety; and
- 5) The information presented is true to the best of their knowledge.

REQUIRED DOCUMENTATION FOR SHBP/SEHBP DEPENDENT ELIGIBILITY AND ENROLLMENT

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

DEPENDENTS	ELIGIBILITY DEFINITION	DOCUMENTATION REQUIRED
SPOUSE	A person of the opposite sex to whom you are legally married.	A photocopy of the <i>Marriage Certificate</i> and a photocopy of the front page of the employee/retiree's most recently filed federal tax return* (Form 1040) that includes the spouse.
CIVIL UNION PARTNER	A person of the same sex with whom you have entered into a civil union.	A photocopy of the <i>New Jersey Civil Union Certificate</i> or a valid certification from another jurisdiction that recognizes same-sex civil unions and a photocopy of the front page of the employee/retiree's most recently filed New Jersey tax return* that includes the partner or a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partners and is received at the same address.
DOMESTIC PARTNER	A person of the same sex with whom you have entered into a domestic partnership. Under Chapter 246, P.L. 2003, the Domestic Partnership Act, health benefits coverage is available to domestic partners of State employees, State retirees, or employees or retirees of a SHBP or SEHBP participating local public entity that has adopted a resolution to provide Chapter 246 health benefits.	A photocopy of the <i>New Jersey Certificate of Domestic Partnership</i> dated prior to February 19, 2007 or a valid certification from another State of foreign jurisdiction that recognizes same-sex domestic partners and a photocopy of the front page of the employee/retiree's most recently filed New Jersey tax return* that includes the partner or a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partners and is received at the same address.
CHILDREN	A subscriber's child until age 26, regardless of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his or her parents. This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation. Coverage until age 26 is only available if an adult child is not eligible to enroll in other employer-based coverage (aside from coverage through the parent).	Natural or Adopted Child – A photocopy of the child's birth certificate showing the name of the employee/retiree as a parent. Step Child – A photocopy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent and a photocopy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner. Legal Guardian, Grandchild, or Foster Child – Photocopies of Final Court Orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the covered employee.
DEPENDENT CHILDREN WITH DISABILITIES	If a covered child is not capable of self-support when he or she reaches age 26 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuance of coverage. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP/SEHBP, and (2) the child continues to be disabled, and (3) the child is unmarried or does not enter into a civil union or domestic partnership, and (4) the child remains substantially dependent on you for support and maintenance. You may be contacted periodically to verify that the child remains eligible for coverage.	Documentation for the appropriate "Child" type (as noted above) and a photocopy of the front page of the employee/retiree's most recently filed federal tax return* (Form 1040) that includes the child. If Social Security disability has been awarded, or is currently pending, please include this information with the documentation that is submitted. Please note that this information is only verifying the child's eligibility as a dependent. The disability status of the child is determined through a separate process.
CONTINUED COVERAGE FOR OVER AGE CHILDREN	Certain children over age 26 may be eligible for continued coverage until age 31 under the provisions of Chapter 375, P.L. 2005. This includes a child by blood or law who: (1) is under the age of 31; (2) is unmarried or not a partner in a civil union or domestic partnership; (3) has no dependent(s) of his or her own; (4) is a resident of New Jersey or is a student at an accredited public or private institution of higher education, with at least 15 credit hours; and (5) 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.	Documentation for the appropriate "Child" type (as noted above) and a photocopy of the front page of the child's most recently filed federal tax return* (Form 1040), and if the child resides outside of the State of New Jersey, documentation of full time student status must be submitted.

* **Note:** For tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers. To obtain copies of the documents listed above, contact the office of the Town Clerk in the city of the birth, marriage, etc., or visit these Web sites: www.vitalrec.com or www.studentclearinghouse.org Residents of New Jersey can obtain records from the State Bureau of Vital Statistics and Registration Web site: www.state.nj.us/health/vital/index.shtml

STATE ACTIVE EMPLOYEES — APPROVED MEDICAL PLAN DESIGNS — PLAN YEAR 2012

	HORIZON PLANS				AETNA PLANS				CIGNA PLANS						
	NJ DIRECT15	NJ DIRECT1525	NJ DIRECT2030	NJ DIRECT HD4000*	NJ DIRECT HD1500*	Aetna HMO	Aetna 1525	Aetna 2030	Aetna HD4000*	Aetna HD1500*	CIGNA HMO	CIGNA 1525	CIGNA 2030	CIGNA HD4000*	CIGNA HD1500*
Medical Cost Sharing															
Primary Care Copayment	\$15	\$15	\$20	\$30/adult \$20/child**	\$15	\$15	\$20	\$20	\$15	\$15	\$15	\$15	\$20	\$30/adult \$20/child**	\$15
Specialist Care Copayment	\$15	\$25	\$30/adult \$20/child**	\$15	\$15	\$25	\$30/adult \$20/child**	\$25	\$25	\$25	\$15	\$25	\$30/adult \$20/child**	\$25	\$25
Emergency Room Copayment	\$50	\$75	\$125	\$50	\$50	\$75	\$125	\$75	\$75	\$50	\$75	\$75	\$125	\$125	\$125
In-Network Deductible															
In-Network Coinsurance	10% (On select services)	10% (On select services)	10% (On select services)	20% after deductible	20% after deductible	10% deductible then 100%	10% deductible then 100%	10% deductible then 100%	20% after deductible	20% after deductible	\$100 deductible then 100%	\$100 deductible then 100%	\$100 deductible then 100%	20% after deductible	20% after deductible
In-Network Out-of-Pocket Maximum (Individual) ¹	\$400	\$400	\$800	\$1,000	\$1,000	\$4,000	\$1,500	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000
Out-of-Network Deductible (Individual) ¹	\$100	\$100	\$200	See In-Network Deductible ²	See In-Network Deductible ²										
Out-of-Network Coinsurance (Individual) ³	30%	30%	30%	40%	40%										
Out-of-Network Out-of-Pocket Maximum (Individual) ¹	\$2,000	\$2,000	\$5,000	\$2,000	\$2,000										
Out-of-Network Inpatient Hospital Deductible	\$200/stay	\$200/stay	\$500/stay												
Employer Health Savings Account Funding ⁴				\$300	\$300										\$300
Prescription Drug Copays															
Retail: Tier 1 Copayments	\$3.00	\$7.00	\$3.00			\$3.00	\$7.00	\$3.00	\$7.00	\$3.00	\$3.00	\$7.00	\$3.00	\$3.00	\$3.00
Retail: Tier 2 Copayments	\$10.00	\$16.00	\$18.00			\$10.00	\$16.00	\$18.00	\$16.00	\$18.00	\$10.00	\$16.00	\$18.00	\$18.00	\$18.00
Retail: Tier 3 Copayments	\$25.00	\$35.00	\$46.00			\$25.00	\$35.00	\$46.00	\$35.00	\$46.00	\$25.00	\$35.00	\$46.00	\$46.00	\$46.00
Mail: Tier 1 Copayments	\$5.00	\$18.00	\$5.00			\$5.00	\$18.00	\$5.00	\$18.00	\$5.00	\$5.00	\$18.00	\$5.00	\$5.00	\$5.00
Mail: Tier 2 Copayments	\$15.00	\$40.00	\$36.00			\$15.00	\$40.00	\$36.00	\$40.00	\$36.00	\$15.00	\$40.00	\$36.00	\$36.00	\$36.00
Mail: Tier 3 Copayments	\$40.00	\$88.00	\$92.00			\$40.00	\$88.00	\$92.00	\$88.00	\$92.00	\$40.00	\$88.00	\$92.00	\$92.00	\$92.00

* HD = High Deductible Health Plan

** Up to 15th Birthday

¹ Family amounts are 2 times the individual amounts for the high deductible plans and 2.5 for all other plans.

² Out-of-Network Deductible is combined with In-Network Deductible.

³ After Deductible.

⁴ Health Savings Accounts can be used for qualified medical expenses without federal tax liability.

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DEPARTMENT OF THE TREASURY - DIVISION OF PENSIONS AND BENEFITS
NEW JERSEY STATE HEALTH BENEFITS PROGRAM

STATE BIWEEKLY ACTIVE GROUP
BIWEEKLY RATES EFFECTIVE 12/31/2011 to 12/28/2012

PLAN/COVERAGE DESCRIPTION	BIWEEKLY TOTAL
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MEDICAL PLANS AVAILABLE WITH PRESCRIPTION DRUG PROGRAM #203

<u>NJ DIRECT15 - #150(1)</u>	
Single	\$253.32
Member & Spouse/Partner	\$506.64
Family	\$633.30
Parent & Child	\$374.91
<u>AETNA, INC. - #005(1)</u>	
Single	\$260.38
Member & Spouse/Partner	\$520.77
Family	\$650.96
Parent & Child	\$385.37
<u>CIGNA HealthCare HMO - #006(1)</u>	
Single	\$261.78
Member & Spouse/Partner	\$523.57
Family	\$654.46
Parent & Child	\$387.44
<u>PRESCRIPTION DRUG PROGRAM - #203</u>	
Single	\$70.50
Member & Spouse/Partner	\$141.00
Family	\$176.26
Parent & Child	\$104.34

MEDICAL PLANS AVAILABLE WITH PRESCRIPTION DRUG #205

<u>NJ DIRECT1525 #051(2)</u>	
Single	\$246.22
Member & Spouse/Partner	\$492.45
Family	\$615.57
Parent & Child	\$364.41
<u>AETNA 1525 #061(2)</u>	
Single	\$253.09
Member & Spouse/Partner	\$506.19
Family	\$632.74
Parent & Child	\$374.58
<u>CIGNA 1525 #071(2)</u>	
Single	\$254.45
Member & Spouse/Partner	\$508.91
Family	\$636.14
Parent & Child	\$376.59
<u>PRESCRIPTION DRUG PROGRAM #205</u>	
Single	\$63.94
Member & Spouse/Partner	\$127.89
Family	\$159.87
Parent & Child	\$94.64

- 1) Subscribers in # 150, #005, & #006 are subject to \$15 Primary Care and \$15 Specialist office visit copayment and are eligible for Prescription Drug Plan #203
- 2) Subscribers in #051, #061, & #071 are subject to \$15 Primary Care and \$25 Specialist office visit copayment and are eligible for Prescription Drug Plan #205
- 3) Subscribers in # 052, #062, & #072 are subject to \$20 Primary Care and \$30 adult/\$20 child Specialist office visit copayment and are eligible for Prescription Drug Plan #205
- 4) Subscribers in High Deductible Plans #90, #92, #94 are subject to \$4,000 In-Network deductible
- 5) Subscribers in High Deductible Plans #91, #93, #95 are subject to \$1,500 In-Network deductible

DEPARTMENT OF THE TREASURY - DIVISION OF PENSIONS AND BENEFITS
NEW JERSEY STATE HEALTH BENEFITS PROGRAM

STATE BIWEEKLY ACTIVE GROUP
BIWEEKLY RATES EFFECTIVE 12/31/2011 to 12/28/2012

PLAN/COVERAGE DESCRIPTION	BIWEEKLY TOTAL
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MEDICAL PLANS AVAILABLE WITH PRESCRIPTION DRUG PROGRAM #206

<u>NJ DIRECT2030 #052(3)</u>	
Single	\$231.53
Member & Spouse/Partner	\$463.07
Family	\$578.84
Parent & Child	\$342.66
<u>AETNA 2030 #062(3)</u>	
Single	\$237.99
Member & Spouse/Partner	\$476.98
Family	\$694.98
Parent & Child	\$352.23
<u>CIGNA 2030 #072(3)</u>	
Single	\$239.27
Member & Spouse/Partner	\$478.54
Family	\$598.18
Parent & Child	\$354.12
<u>PRESCRIPTION DRUG PROGRAM #206</u>	
Single	\$65.07
Member & Spouse/Partner	\$130.14
Family	\$162.68
Parent & Child	\$96.30

HIGH DEDUCTIBLE HEALTH PLANS WITH BUILT IN PRESCRIPTION DRUG

<u>NJ DIRECT HD4000 #090(4)</u>	
Single	\$185.00
Member & Spouse/Partner	\$370.02
Family	\$462.52
Parent & Child	\$273.81
<u>AETNA HD4000 #092(4)</u>	
Single	\$189.04
Member & Spouse/Partner	\$378.09
Family	\$472.62
Parent & Child	\$279.78
<u>CIGNA HD4000 #094(4)</u>	
Single	\$189.84
Member & Spouse/Partner	\$379.69
Family	\$474.61
Parent & Child	\$280.97
<u>NJ DIRECT HD1500 #091(5)</u>	
Single	\$274.39
Member & Spouse/Partner	\$548.78
Family	\$685.98
Parent & Child	\$406.09
<u>AETNA HD1500 #093(5)</u>	
Single	\$280.37
Member & Spouse/Partner	\$560.75
Family	\$700.95
Parent & Child	\$414.95
<u>CIGNA HD1500 #095 (5)</u>	
Single	\$281.56
Member & Spouse/Partner	\$563.13
Family	\$703.91
Parent & Child	\$416.71

- 1) Subscribers in # 150, #005, & #006 are subject to \$15 Primary Care and \$15 Specialist office visit copayment and are eligible for Prescription Drug Plan #203
 2) Subscribers in #051, #061, & #071 are subject to \$15 Primary Care and \$25 Specialist office visit copayment and are eligible for Prescription Drug Plan #205
 3) Subscribers in # 052, #062, & #072 are subject to \$20 Primary Care and \$30 adult/\$20 child Specialist office visit copayment and are eligible for Prescription Drug Plan #206
 4) Subscribers in High Deductible Plans #90, #92, #94 are subject to \$4,000 In-Network deductible
 5) Subscribers in High Deductible Plans #91, #93, #95 are subject to \$1,500 In-Network deductible

DEPARTMENT OF THE TREASURY - DIVISION OF PENSIONS AND BENEFITS
NEW JERSEY STATE HEALTH BENEFITS PROGRAM

STATE BIWEEKLY ACTIVE GROUP
BIWEEKLY RATES EFFECTIVE 12/31/2011 to 12/28/2012

DENTAL PLANS

DESCRIPTION OF COVERAGE	STATE CONTRIBUTION	EMPLOYEE CONTRIBUTION	BIWEEKLY TOTAL
DENTAL EXPENSE PLAN - #399			
SINGLE	\$8.92	\$8.90	\$17.82
Member & Spouse/Partner	\$16.49	\$16.47	\$30.96
FAMILY	\$26.34	\$26.32	\$50.66
PARENT & CHILD	\$18.76	\$18.76	\$37.52
DENTAL PROVIDER ORGANIZATIONS (DPO)			
BENECARE (DPO #301)			
SINGLE	\$6.97	\$6.97	\$11.94
Member & Spouse/Partner	\$10.37	\$10.37	\$20.74
FAMILY	\$16.98	\$16.97	\$33.95
PARENT & CHILD	\$12.57	\$12.57	\$25.14
COMMUNITY DENTAL (DPO #302)			
SINGLE	\$6.54	\$6.52	\$11.06
Member & Spouse/Partner	\$9.62	\$9.61	\$19.23
FAMILY	\$15.73	\$16.72	\$31.45
PARENT & CHILD	\$11.65	\$11.64	\$23.29
CIGNA (DPO #305)			
SINGLE	\$5.13	\$5.11	\$10.24
Member & Spouse/Partner	\$8.90	\$8.90	\$17.80
FAMILY	\$14.56	\$14.55	\$29.11
PARENT & CHILD	\$10.80	\$10.78	\$21.58
HEALTHPLEX (DPO #307)			
SINGLE	\$4.27	\$4.26	\$8.53
Member & Spouse/Partner	\$7.42	\$7.41	\$14.83
FAMILY	\$12.13	\$12.12	\$24.25
PARENT & CHILD	\$8.99	\$8.98	\$17.97
HORIZON DENTAL CHOICE (DPO #317)			
SINGLE	\$4.73	\$4.73	\$9.46
Member & Spouse/Partner	\$8.22	\$8.22	\$16.44
FAMILY	\$13.46	\$13.44	\$26.90
PARENT & CHILD	\$9.97	\$9.96	\$19.93
AETNA DMO (DPO #319)			
SINGLE	\$4.96	\$4.96	\$9.91
Member & Spouse/Partner	\$8.64	\$8.62	\$17.26
FAMILY	\$14.12	\$14.10	\$28.22
PARENT & CHILD	\$10.46	\$10.45	\$20.91

STATE HEALTH BENEFITS PROGRAM

PERCENTAGE OF PREMIUM CALCULATION CHARTS

For Health Benefit Contributions under Chapter 78, P.L. 2011

(State Employees Paid Biweekly through Centralized Payroll)

Use this worksheet and the attached charts to calculate your combined Health Benefit Contribution.

Calculate Premium Percentages		
1.	Use the SHBP Premium Rate Chart and enter the premium amount for your SHBP Medical Plan at your selected Level of Coverage.	\$
2.	Use the Percentage of Premium Chart for your Level of Coverage to find your Salary Range and Percentage of Premium amount.	%
3.	Calculate your Medical Plan Contribution: Multiply the Medical Plan Premium by the Premium Percentage.	\$
<i>(For example: If NJ DIRECT15, Family coverage is \$574.82 per pay period, and your premium percentage is 10.0%; the calculation is \$574.82 X 0.10 = \$57.48 per pay period.)</i>		
4.	Use the SHBP Premium Rate Chart and enter the premium amount for the SHBP Prescription Drug Plan at your selected Level of Coverage.	\$
5.	Use the Percentage of Premium Chart for your Level of Coverage to find your Salary Range and Percentage of Premium amount.	%
6.	Calculate your Prescription Drug Plan Contribution: Multiply the Prescription Drug Plan Premium by the Premium Percentage.	\$
7.	Add Line #3 and Line #6. <i>(Medical Plan Contribution + Prescription Drug Plan Contribution)</i>	\$
Calculate Minimum Required Contribution		
<i>Employees must pay a minimum of 1.5% of Annual Salary</i>		
8.	Enter your total Annual Salary.	\$
9.	Multiply your Annual Salary by 1.5% (Salary X 0.015).	X 0.015
10.	This is your 1.5% Minimum <i>annual</i> percentage of salary.	\$
11.	Divide the annual amount on Line #10 by 26 pay periods.	÷ 26
12.	This is the minimum biweekly amount you are required to contribute.	\$
Your Health Benefit Contribution		
13.	If the amount on Line #7 is larger than the amount on Line #12, enter it here. Otherwise, enter the amount on Line #12.	\$
This is Your Biweekly Required Contribution		

The calculations from this worksheet are approximations and may differ from the actual amounts deducted from payroll.

STATE OF NEW JERSEY — DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS
STATE HEALTH BENEFITS PROGRAM
SHBP PLAN PREMIUM RATE CHART

STATE BIWEEKLY ACTIVE GROUP
 BIWEEKLY RATES EFFECTIVE 12/31/2011 to 12/28/2012

PLAN/COVERAGE DESCRIPTION	BIWEEKLY TOTAL
------------------------------	-------------------

MEDICAL PLANS AVAILABLE WITH PRESCRIPTION DRUG PROGRAM #203

<u>NJ DIRECT15 - #150(1)</u>	
Single	\$253.32
Member & Spouse/Partner	\$506.64
Family	\$633.30
Parent & Child	\$374.91
<u>AETNA, INC. - #005(1)</u>	
Single	\$260.38
Member & Spouse/Partner	\$520.77
Family	\$650.96
Parent & Child	\$385.37
<u>CIGNA HealthCare HMO - #006(1)</u>	
Single	\$261.78
Member & Spouse/Partner	\$523.57
Family	\$654.46
Parent & Child	\$387.44
<u>PRESCRIPTION DRUG PROGRAM - #203</u>	
Single	\$70.50
Member & Spouse/Partner	\$141.00
Family	\$176.26
Parent & Child	\$104.34

MEDICAL PLANS AVAILABLE WITH PRESCRIPTION DRUG #205

<u>NJ DIRECT1525 #051(2)</u>	
Single	\$246.22
Member & Spouse/Partner	\$492.45
Family	\$615.57
Parent & Child	\$364.41
<u>AETNA 1525 #061(2)</u>	
Single	\$253.09
Member & Spouse/Partner	\$506.19
Family	\$632.74
Parent & Child	\$374.58
<u>CIGNA 1525 #071(2)</u>	
Single	\$254.45
Member & Spouse/Partner	\$508.91
Family	\$636.14
Parent & Child	\$376.59
<u>PRESCRIPTION DRUG PROGRAM #205</u>	
Single	\$63.94
Member & Spouse/Partner	\$127.89
Family	\$159.87
Parent & Child	\$94.64

- 1) Subscribers in # 150, #005, & #006 are subject to \$15 Primary Care and \$15 Specialist office visit copayment and are eligible for Prescription Drug Plan #203
- 2) Subscribers in #051, #061, & #071 are subject to \$15 Primary Care and \$25 Specialist office visit copayment and are eligible for Prescription Drug Plan #205
- 3) Subscribers in # 052, #062, & #072 are subject to \$20 Primary Care and \$30 adult/\$20 child Specialist office visit copayment and are eligible for Prescription Drug Plan #206
- 4) Subscribers in High Deductible Plans #90, #92, #94 are subject to \$4,000 In-Network deductible
- 5) Subscribers in High Deductible Plans #91, #93, #95 are subject to \$1,500 In-Network deductible

STATE OF NEW JERSEY — DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS
STATE HEALTH BENEFITS PROGRAM
SHBP PLAN PREMIUM RATE CHART

STATE BIWEEKLY ACTIVE GROUP
 BIWEEKLY RATES EFFECTIVE 12/31/2011 to 12/28/2012

PLAN/COVERAGE DESCRIPTION	BIWEEKLY TOTAL
------------------------------	-------------------

MEDICAL PLANS AVAILABLE WITH PRESCRIPTION DRUG PROGRAM #206

<u>NJ DIRECT2030 #052(3)</u>	
Single	\$231.53
Member & Spouse/Partner	\$463.07
Family	\$578.84
Parent & Child	\$342.66
<u>AETNA 2030 #062(3)</u>	
Single	\$237.99
Member & Spouse/Partner	\$475.98
Family	\$594.98
Parent & Child	\$352.23
<u>CIGNA 2030 #072(3)</u>	
Single	\$239.27
Member & Spouse/Partner	\$478.54
Family	\$598.18
Parent & Child	\$354.12
<u>PRESCRIPTION DRUG PROGRAM #206</u>	
Single	\$65.07
Member & Spouse/Partner	\$130.14
Family	\$162.68
Parent & Child	\$96.30

HIGH DEDUCTIBLE HEALTH PLANS WITH BUILT IN PRESCRIPTION DRUG

<u>NJ DIRECT HD4000 #090(4)</u>	
Single	\$185.00
Member & Spouse/Partner	\$370.02
Family	\$462.52
Parent & Child	\$273.81
<u>AETNA HD4000 #092(4)</u>	
Single	\$189.04
Member & Spouse/Partner	\$378.09
Family	\$472.62
Parent & Child	\$279.78
<u>CIGNA HD4000 #094(4)</u>	
Single	\$189.84
Member & Spouse/Partner	\$379.69
Family	\$474.61
Parent & Child	\$280.97
<u>NJ DIRECT HD1500 #091(5)</u>	
Single	\$274.39
Member & Spouse/Partner	\$548.78
Family	\$685.98
Parent & Child	\$406.09
<u>AETNA HD1500 #093(5)</u>	
Single	\$280.37
Member & Spouse/Partner	\$560.75
Family	\$700.95
Parent & Child	\$414.95
<u>CIGNA HD1500 #095 (5)</u>	
Single	\$281.56
Member & Spouse/Partner	\$563.13
Family	\$703.91
Parent & Child	\$416.71

1) Subscribers in # 150, #005, & #006 are subject to \$15 Primary Care and \$15 Specialist office visit copayment and are eligible for Prescription Drug Plan #203

2) Subscribers in #051, #061, & #071 are subject to \$15 Primary Care and \$25 Specialist office visit copayment and are eligible for Prescription Drug Plan #205

3) Subscribers in # 052, #082, & #072 are subject to \$20 Primary Care and \$30 adult/\$20 child Specialist office visit copayment and are eligible for Prescription Drug Plan #206

4) Subscribers in High Deductible Plans #90, #92, #94 are subject to \$4,000 In-Network deductible

5) Subscribers in High Deductible Plans #91, #93, #95 are subject to \$1,500 In-Network deductible

STATE OF NEW JERSEY — DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS
STATE HEALTH BENEFITS PROGRAM

PERCENTAGE OF PREMIUM CHARTS

For Health Benefit Contributions under Chapter 78, P.L. 2011

Note: The following charts reflect the phase-in of contribution levels for employees employed on the contribution's effective date who will pay $\frac{1}{4}$, $\frac{1}{2}$, $\frac{3}{4}$ and the full amount of the contribution rate during the phase-in years.

New employees hired on or after June 28, 2011, the effective date of Chapter 78, P.L. 2011, contribute at the highest percentage level (Year 4) — except Judiciary employees whose positions are covered by the Collective Negotiations Agreement that will expire June 30, 2012.

HEALTH BENEFITS CONTRIBUTION FOR SINGLE COVERAGE (PERCENTAGE OF PREMIUM)*

Salary Range	Four Year Phase-In <i>Use dates indicated or as otherwise determined by contract</i>			
	Year 1 July 2011 to June 2012	Year 2 July 2012 to June 2013	Year 3 July 2013 to June 2014	Year 4 July 2014 and after
less than 20,000	1.13%	2.25%	3.38%	4.50%
20,000-24,999.99	1.38%	2.75%	4.13%	5.50%
25,000-29,999.99	1.88%	3.75%	5.63%	7.50%
30,000-34,999.99	2.50%	5.00%	7.50%	10.00%
35,000-39,999.99	2.75%	5.50%	8.25%	11.00%
40,000-44,999.99	3.00%	6.00%	9.00%	12.00%
45,000-49,999.99	3.50%	7.00%	10.50%	14.00%
50,000-54,999.99	5.00%	10.00%	15.00%	20.00%
55,000-59,999.99	5.75%	11.50%	17.25%	23.00%
60,000-64,999.99	6.75%	13.50%	20.25%	27.00%
65,000-69,999.99	7.25%	14.50%	21.75%	29.00%
70,000-74,999.99	8.00%	16.00%	24.00%	32.00%
75,000-79,999.99	8.25%	16.50%	24.75%	33.00%
80,000-94,999.99	8.50%	17.00%	25.50%	34.00%
95,000 and over	8.75%	17.50%	26.25%	35.00%

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

STATE OF NEW JERSEY — DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS
STATE HEALTH BENEFITS PROGRAM

HEALTH BENEFITS CONTRIBUTION FOR FAMILY COVERAGE
(PERCENTAGE OF PREMIUM)*

Salary Range	Four Year Phase-In			
	<i>Use dates indicated or as otherwise determined by contract</i>			
	Year 1 July 2011 to June 2012	Year 2 July 2012 to June 2013	Year 3 July 2013 to June 2014	Year 4 July 2014 and after
less than 25,000	0.75%	1.50%	2.25%	3.00%
25,000-29,999.99	1.00%	2.00%	3.00%	4.00%
30,000-34,999.99	1.25%	2.50%	3.75%	5.00%
35,000-39,999.99	1.50%	3.00%	4.50%	6.00%
40,000-44,999.99	1.75%	3.50%	5.25%	7.00%
45,000-49,999.99	2.25%	4.50%	6.75%	9.00%
50,000-54,999.99	3.00%	6.00%	9.00%	12.00%
55,000-59,999.99	3.50%	7.00%	10.50%	14.00%
60,000-64,999.99	4.25%	8.50%	12.75%	17.00%
65,000-69,999.99	4.75%	9.50%	14.25%	19.00%
70,000-74,999.99	5.50%	11.00%	16.50%	22.00%
75,000-79,999.99	5.75%	11.50%	17.25%	23.00%
80,000-84,999.99	6.00%	12.00%	18.00%	24.00%
85,000-89,999.99	6.50%	13.00%	19.50%	26.00%
90,000-94,999.99	7.00%	14.00%	21.00%	28.00%
95,000-99,999.99	7.25%	14.50%	21.75%	29.00%
100,000-109,999.99	8.00%	16.00%	24.00%	32.00%
110,000 and over	8.75%	17.50%	26.25%	35.00%

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

STATE OF NEW JERSEY — DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS
STATE HEALTH BENEFITS PROGRAM

**HEALTH BENEFITS CONTRIBUTION FOR
MEMBER/SPOUSE/PARTNER OR PARENT/CHILD COVERAGE
(PERCENTAGE OF PREMIUM)***

Salary Range	Four Year Phase-In <i>Use dates indicated or as otherwise determined by contract</i>			
	Year 1 July 2011 to June 2012	Year 2 July 2012 to June 2013	Year 3 July 2013 to June 2014	Year 4 July 2014 and after
less than 25,000	0.88%	1.75%	2.63%	3.50%
25,000-29,999.99	1.13%	2.25%	3.38%	4.50%
30,000-34,999.99	1.50%	3.00%	4.50%	6.00%
35,000-39,999.99	1.75%	3.50%	5.25%	7.00%
40,000-44,999.99	2.00%	4.00%	6.00%	8.00%
45,000-49,999.99	2.50%	5.00%	7.50%	10.00%
50,000-54,999.99	3.75%	7.50%	11.25%	15.00%
55,000-59,999.99	4.25%	8.50%	12.75%	17.00%
60,000-64,999.99	5.25%	10.50%	15.75%	21.00%
65,000-69,999.99	5.75%	11.50%	17.25%	23.00%
70,000-74,999.99	6.50%	13.00%	19.50%	26.00%
75,000-79,999.99	6.75%	13.50%	20.25%	27.00%
80,000-84,999.99	7.00%	14.00%	21.00%	28.00%
85,000-99,999.99	7.50%	15.00%	22.50%	30.00%
100,000 and over	8.75%	17.50%	26.25%	35.00%

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

**COMPLETING THE PART-TIME EMPLOYEES GROUP
NJ STATE HEALTH BENEFITS PROGRAM APPLICATION**

QUICK REFERENCE

- This application is for use by part-time State employees and part-time faculty members at a state college or university, or county or community college who are eligible for State Health Benefits Program coverage under Chapter 172, P.L. 2003. For more information about this law and the eligibility requirements for Part-time employees, see Fact Sheet #66, *SHBP Coverage for State Part-time Employees*.
- To **enroll** for the first time complete all sections of the application with the exception of section 5.
- To **change coverage level** (adding/deleting dependents) complete sections: 1, 2a, 2b, and 2c (if applicable), 4, (be sure to list all eligible dependents), 5 (listing why you are changing coverage level), and 6.
- To **add a dependent** complete sections: 1, 2a, and (as applicable) 2b and/or 2c, 4 (list all eligible dependents), 5a, and 6. You must also attach required proof of dependency documentation.
- To **terminate/decline coverage** complete sections: 1, 2a and/or 3b to terminate/decline prescription drug coverage, and 6. Note: If you are declining enrollment for yourself or your eligible dependents because of other group health insurance coverage, you may in the future be able to enroll yourself and/or your eligible dependents in a SHBP medical plan, provided that you request enrollment within 60 days after your other group health coverage ends.

SECTION 1 — EMPLOYEE INFORMATION

This section must be completed in its entirety each time an application is submitted. The employee enrolling or enrolled in the plan completes this section.

SECTION 2 — MEDICAL COVERAGE

2b. Check only one box indicating the medical plan and Employee Prescription Drug Plan coverage or medical plan coverage only.

2c. Check the coverage level desired.

SECTION 3 — LEVEL OF PRESCRIPTION DRUG PLAN COVERAGE

Check the coverage level desired.

Note: Once you decline or cancel coverage, enrollment is not normally permissible until the next open enrollment period or if other coverage is lost and proof of loss is provided (HIPAA).

SECTION 4 — DEPENDENT INFORMATION

Only eligible dependents may be listed. Completion of this section is essential for proper enrollment. Be sure dependents listed agree with the level of coverage selected in sections 2b and 2c. List the name, date of birth, gender, and Social Security number of the family members you wish to be covered under the plan. You may cover an eligible spouse, civil union partner, or eligible same-sex domestic partner, or your child under age 26 (as defined below).

SPOUSE: This is a person of the opposite sex to whom you are legally married. A photocopy of the *Marriage Certificate* and a photocopy of the employee's most recent Federal tax return* that includes the spouse are required for enrollment.

CIVIL UNION PARTNER: This is a person of the same sex with whom you have entered into a civil union. A photocopy of the New Jersey *Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions and a photocopy of the employee's most recent Federal tax return* that includes the partner are required for enrollment. The cost of a civil union partner's coverage may be subject to federal tax (see Fact Sheet #75, *Civil Unions*, for details).

DOMESTIC PARTNER: This is a same-sex domestic partner, as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act, of any State employee, State retiree, or an eligible employee or retiree of a SHBP participating local public entity if the local governing body adopts a resolution to provide Chapter 246 health benefits. A photocopy of the New Jersey *Certificate of Domestic Partnership* dated prior to February 19, 2007 or a valid certification from another jurisdiction that recognizes same-sex domestic partners and a photocopy of the employee's most recent Federal tax return* that includes the partner are required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see Fact Sheet #71, *Benefits Under the Domestic Partnership Act*, for details).

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

CHILDREN: This is your child under age 26. A photocopy of a child's birth certificate showing the name of the employee as a parent is required for enrollment. If you have listed a child who is an adopted child, foster child, stepchild, legal ward, has a different last name than the employee, or if the member has a Parent/Child contract, additional supporting documentation is required. A child is only eligible if he or she is not eligible to enroll in other employer-based coverage (aside from coverage through the parent). If you have more than four eligible dependent children, attach a separate application and complete Sections 1, 4, and 6.

Note: If you are deleting dependents, do not list them in this section. Refer to section 5b and 5c.

SECTION 5 — TYPE OF ACTIVITY

5a. If you are adding a dependent, check the appropriate box and the event date.

5b. If you are deleting a dependent spouse/partner, check reason and indicate the event date.

5c. If you are deleting a dependent child, indicate the event date, list the child's Social Security number, and give reason.

5d. For other changes, check the appropriate box and give reason.

SECTION 6 — EMPLOYEE CERTIFICATION

You must read the Employee Certification statement, sign it, and date the application.

Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

EMPLOYER CERTIFICATION

Must be completed by your employer. This application must be certified by the employer before submitting it to the SHBP. The Certifying Officer should:

- 1) Verify the employee's eligibility;
- 2) Verify that the application is legible and completed in its entirety;
- 3) Verify that the employee's selected plans and coverage levels are appropriate; and
- 4) Complete the Employer Certification section in its entirety.

For New Enrollments: The employer must provide the employee's Date of Pension Enrollment (if employee is a new enrollee, enter expected enrollment date based upon submission of the pension Enrollment Application) or the employee's Pension Membership Number.

REQUIRED DOCUMENTATION FOR SHBP/SEHBP DEPENDENT ELIGIBILITY AND ENROLLMENT

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

DEPENDENTS	ELIGIBILITY DEFINITION	DOCUMENTATION REQUIRED
SPOUSE	A person of the opposite sex to whom you are legally married.	A photocopy of the <i>Marriage Certificate</i> and a photocopy of the front page of the employee/retiree's most recently filed federal tax return* (<i>Form 1040</i>) that includes the spouse.
CIVIL UNION PARTNER	A person of the same sex with whom you have entered into a civil union.	A photocopy of the <i>New Jersey Civil Union Certificate</i> or a valid certification from another jurisdiction that recognizes same-sex civil unions and a photocopy of the front page of the employee/retiree's most recently filed New Jersey tax return* that includes the partner or a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partners and is received at the same address.
DOMESTIC PARTNER	A person of the same sex with whom you have entered into a domestic partnership. Under Chapter 246, P.L. 2003, the Domestic Partnership Act, health benefits coverage is available to domestic partners of State employees, State retirees, or employees or retirees of a SHBP or SEHBP participating local public entity that has adopted a resolution to provide Chapter 246 health benefits.	A photocopy of the <i>New Jersey Certificate of Domestic Partnership</i> dated prior to February 19, 2007 or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners and a photocopy of the front page of the employee/retiree's most recently filed New Jersey tax return* that includes the partner or a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partners and is received at the same address.
CHILDREN	A subscriber's child until age 26, regardless of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his or her parents. This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation. Coverage until age 26 is only available if an adult child is not eligible to enroll in other employer-based coverage (aside from coverage through the parent).	Natural or Adopted Child – A photocopy of the child's birth certificate showing the name of the employee/retiree as a parent. Step Child – A photocopy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent and a photocopy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner. Legal Guardian, Grandchild, or Foster Child – Photocopies of Final Court Orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the covered employee.
DEPENDENT CHILDREN WITH DISABILITIES	If a covered child is not capable of self-support when he or she reaches age 26 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuance of coverage. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP/SEHBP; and (2) the child continues to be disabled, and (3) the child is unmarried or does not enter into a civil union or domestic partnership, and (4) the child remains substantially dependent on you for support and maintenance. You may be contacted periodically to verify that the child remains eligible for coverage.	Documentation for the appropriate "Child" type (as noted above) and a photocopy of the front page of the employee/retiree's most recently filed federal tax return* (<i>Form 1040</i>) that includes the child. If Social Security disability has been awarded, or is currently pending, please include this information with the documentation that is submitted. Please note that this information is only verifying the child's eligibility as a dependent. The disability status of the child is determined through a separate process.
CONTINUED COVERAGE FOR OVER AGE CHILDREN	Certain children over age 26 may be eligible for continued coverage until age 31 under the provisions of Chapter 375, P.L. 2005. This includes a child by blood or law who: (1) is under the age of 31; (2) is unmarried or not a partner in a civil union or domestic partnership; (3) has no dependent(s) of his or her own; (4) is a resident of New Jersey or is a student at an accredited public or private institution of higher education, with at least 15 credit hours; and (5) 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.	Documentation for the appropriate "Child" type (as noted above) and a photocopy of the front page of the child's most recently filed federal tax return* (<i>Form 1040</i>), and if the child resides outside of the State of New Jersey, documentation of full time student status must be submitted.

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

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

DEPARTMENT OF THE TREASURY - DIVISION OF PENSIONS AND BENEFITS
NEW JERSEY STATE HEALTH BENEFITS PROGRAM

CHAPTER 172 PART-TIME STATE MONTHLY ACTIVE GROUP
MONTHLY RATES EFFECTIVE 1/1/2012 to 12/31/2012

PLAN/COVERAGE DESCRIPTION	PART-TIME MONTHLY TOTAL
MEDICAL PLANS AVAILABLE WITH PRESCRIPTION DRUG PROGRAM #203	
<u>NJ DIRECT15 - #150(1)</u>	
Single	\$606.37
Member & Spouse/Partner	\$1,210.74
Family	\$1,513.43
Parent & Child	\$895.95
<u>AETNA, INC. - #005(1)</u>	
Single	\$622.25
Member & Spouse/Partner	\$1,244.51
Family	\$1,555.65
Parent & Child	\$920.94
<u>CIGNA HealthCare HMO - #006(1)</u>	
Single	\$626.60
Member & Spouse/Partner	\$1,251.20
Family	\$1,564.01
Parent & Child	\$925.89
<u>PRESCRIPTION DRUG PROGRAM - #203</u>	
Single	\$168.48
Member & Spouse/Partner	\$336.97
Family	\$421.22
Parent & Child	\$249.35

MEDICAL PLANS AVAILABLE WITH PRESCRIPTION DRUG PLAN #205

<u>NJ DIRECT1525 #051(2)</u>	
Single	\$588.42
Member & Spouse/Partner	\$1,176.84
Family	\$1,471.06
Parent & Child	\$870.85
<u>AETNA 1525 #061(2)</u>	
Single	\$604.83
Member & Spouse/Partner	\$1,209.67
Family	\$1,512.09
Parent & Child	\$895.15
<u>CIGNA 1525 #071(2)</u>	
Single	\$608.09
Member & Spouse/Partner	\$1,216.17
Family	\$1,520.22
Parent & Child	\$898.96
<u>PRESCRIPTION DRUG PROGRAM #205</u>	
Single	\$152.82
Member & Spouse/Partner	\$305.63
Family	\$382.05
Parent & Child	\$226.17

- 1) Subscribers in # 150, #005, & #006 are subject to \$15 Primary Care and \$15 Specialist office visit copayment and are eligible for Prescription Drug Plan #203
- 2) Subscribers in #051, #061, & #071 are subject to \$15 Primary Care and \$25 Specialist office visit copayment and are eligible for Prescription Drug Plan #205
- 3) Subscribers in # 052, #052, & #072 are subject to \$20 Primary Care and \$30 adult/\$20 child Specialist office visit copayment and are eligible for Prescription Drug Plan #206
- 4) Subscribers in High Deductible Plans #90, #92, #94 are subject to \$4,000 in-Network deductible
- 5) Subscribers in High Deductible Plans #91, #93, #95 are subject to \$1,500 in-Network deductible

DEPARTMENT OF THE TREASURY - DIVISION OF PENSIONS AND BENEFITS
NEW JERSEY STATE HEALTH BENEFITS PROGRAM

CHAPTER 172 PART-TIME STATE MONTHLY ACTIVE GROUP
MONTHLY RATES EFFECTIVE 1/1/2012 to 12/31/2012

PLAN/COVERAGE DESCRIPTION	PART-TIME MONTHLY TOTAL
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MEDICAL PLANS AVAILABLE WITH PRESCRIPTION DRUG PROGRAM #206

<u>NJ DIRECT2030 #052(3)</u>	
Single	\$553.31
Member & Spouse/Partner	\$1,106.62
Family	\$1,383.28
Parent & Child	\$818.89
<u>AETNA 2030 #062(3)</u>	
Single	\$568.74
Member & Spouse/Partner	\$1,137.48
Family	\$1,421.87
Parent & Child	\$841.74
<u>CIGNA 2030 #072(3)</u>	
Single	\$571.80
Member & Spouse/Partner	\$1,143.60
Family	\$1,429.50
Parent & Child	\$846.26
<u>PRESCRIPTION DRUG PROGRAM #206</u>	
Single	\$155.51
Member & Spouse/Partner	\$311.02
Family	\$388.78
Parent & Child	\$230.15

HIGH DEDUCTIBLE HEALTH PLANS WITH BUILT IN PRESCRIPTION DRUG

<u>Horizon Plan HD4000 #090(4)</u>	
Single	\$442.12
Member & Spouse/Partner	\$884.25
Family	\$1,105.32
Parent & Child	\$654.34
<u>AETNA HD4000 #092(4)</u>	
Single	\$451.77
Member & Spouse/Partner	\$903.55
Family	\$1,129.44
Parent & Child	\$668.62
<u>CIGNA HD4000 #094(4)</u>	
Single	\$453.68
Member & Spouse/Partner	\$907.36
Family	\$1,134.22
Parent & Child	\$671.45
<u>NJ DIRECTHD1500 #091(5)</u>	
Single	\$655.73
Member & Spouse/Partner	\$1,311.46
Family	\$1,639.33
Parent & Child	\$970.47
<u>AETNA HD1500 #093(5)</u>	
Single	\$670.03
Member & Spouse/Partner	\$1,340.07
Family	\$1,675.10
Parent & Child	\$991.65
<u>CIGNA HD1500 #095 (5)</u>	
Single	\$672.87
Member & Spouse/Partner	\$1,345.74
Family	\$1,682.18
Parent & Child	\$995.85

- 1) Subscribers in # 150, #005, & #006 are subject to \$15 Primary Care and \$15 Specialist office visit copayment and are eligible for Prescription Drug Plan #203
- 2) Subscribers in #051, #061, & #071 are subject to \$15 Primary Care and \$25 Specialist office visit copayment and are eligible for Prescription Drug Plan #205
- 3) Subscribers in # 052, #062, & #072 are subject to \$20 Primary Care and \$30 adult/\$20 child Specialist office visit copayment and are eligible for Prescription Drug Plan #206
- 4) Subscribers in High Deductible Plans #80, #92, #94 are subject to \$4,000 In-Network deductible
- 5) Subscribers in High Deductible Plans #91, #93, #95 are subject to \$1,500 In-Network deductible

NEW JERSEY EMPLOYEE DENTAL PLANS APPLICATION Division of Pension and Benefits, P.O. Box 299, Trenton, NJ 08625-0299

DIVISION USE ONLY

1. EMPLOYEE INFORMATION - This section must be filled out completely. Please print or type.

Form for employee information including Social Security Number, Last Name, First Name, Street Address, City, State, ZIP Code, Date of Birth, Gender, Status, and Home Telephone Number.

2. DENTAL COVERAGE

2a. EMPLOYEE SELECTION (You must remain enrolled in the Dental Plan for a minimum of 12 months)

- I wish to be covered under the Dental Expense Plan.
I wish to be covered under a Dental Plan Organization (DPO).

Form for dental plan selection including Name of DPO, DPO#, Name of Dentist or ID#, and Date of Birth.

2b. LEVEL OF COVERAGE

- Single
Member and Spouse/Civil Union Partner
Member and Domestic Partner (see instructions)
Family
Patient and Child(ren)

Effective Dates: Event Reason:

Form for effective dates and event reason.

EMPLOYER CERTIFICATION

Form for employer certification including Employer Name, Payroll #, Union Code, Location #, and 10/12 month employee status.

MEMBER ACTION

- New Enrollment
Date Employment Began
Return from Leave of Absence
Transfer

Signature of Certifying Officer

Telephone # Date Mailed

3. DEPENDENT INFORMATION - List only eligible dependents and attach required proof of dependency documents (see instructions on reverse).

Table for dependent information with columns for Spouse/Civil Union/Domestic Partner, Children, First Name, MI, Date of Birth, Gender, Social Security Number, and Name of Dentist or ID#.

4. TYPE OF ACTIVITY

(complete only if requesting changes to existing coverage)

4a. ADDITION OF DEPENDENT

(attach required proof of dependency documentation)

- Marriage
Date of Event
Former Name
Civil Union/Domestic Partner - Date of Event
Birth of Child
Adoption/Guardianship - proof required

4b. DELETION OF SPOUSE OR PARTNER

- Divorce
Termination of Domestic Partnership
Death

Date of Event (mm/dd/yy)

4c. DELETION OF CHILD

- Deletion of Child - Date of Event
Child's Name
Child's SSN
Give Reason

4d. OTHER CHANGES

- Change in last name only
Change in Soc. Sec. #
Change in Birth Date

(List former name)

(Attach copy of Social Security card)

(List former Soc. Sec. #)

(Attach copy of birth certificate) (List name and correct date)

- Other - give reason (i.e., address change, dependent returns from military service)

5. EMPLOYEE CERTIFICATION - I certify that all the information supplied on this form is true to the best of my knowledge and that it is verifiable. I understand that if I waive my right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment or if other coverage is lost and proof of loss is provided (HIPAA). I understand that I must remain enrolled in the Dental Plan for a minimum of 12 months and that there is no guarantee of continuous participation by dental service providers, either dentists or facilities in the DPO plans. If either my dentist or dental center terminates participation in my selected plan, I must select another dentist or dental center participating in that plan to receive the "in-network" benefit. I authorize any hospital, physician, dentist, or dental care provider to furnish my dental plan or my assignee with such dental information about myself or my covered dependents as the assignee may require.

Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

Employee Signature

Date Completed

INSTRUCTIONS FOR THE EMPLOYEE DENTAL PLANS APPLICATION

- **To change your dentist** with your DPO, contact your dental plan directly. **DO NOT COMPLETE THIS FORM JUST TO CHANGE YOUR DENTIST.**
- **To enroll** for the first time complete all sections of the application with the exception of section 6.
- **To change dental plans only** complete sections: 1, 2a and 2b (if enrolling in a DPO be sure to list the name of your dentist or his/her identification number), 3 (listing all eligible dependents), and 5.
- **To change coverage level** (adding/deleting dependents) complete sections: 1, 2a and 2b, 3 (listing all eligible dependents), 4 (listing why you are changing coverage level), and 5.
- **To add a dependent** complete sections: 1, 2a and 2b, 3 (listing all eligible dependents), 4a, and 5. You must also attach the required proof of dependency documents.
- **To terminate/decline coverage** complete sections: 1, 2a, and 5. If you are declining enrollment for yourself or any or all of your eligible dependents because of other group dental insurance coverage, you may in the future be able to enroll yourself and/or your eligible dependents in a dental plan, provided that you request enrollment within 60 days after your other group health coverage ends.

SECTION 1 - EMPLOYEE INFORMATION

This section is completed in its entirety each time an application is submitted. The employee enrolling/enrolled in the plan completes this section.

SECTION 2 - DENTAL COVERAGE

2a. Check only one box indicating the dental plan you wish to be enrolled in. If you do not want dental coverage or wish to cancel coverage, check the box to waive coverage.

NOTE: Once you decline or cancel Medical, Prescription Drug, or Dental coverage, enrollment is not permissible until the next open enrollment period or if other coverage is lost and proof of loss is provided (HIPAA).

2b. If electing coverage, check the level of coverage desired. (No employee or dependent can be covered under more than one Dental Plan.)

NOTE: Once enrolled, you and your eligible dependents must remain in the plan you elect for a minimum of 12 months before you can switch plans or drop coverage.

SECTION 3 - DEPENDENT INFORMATION — Only eligible dependents may be listed. Completion of this section is essential for proper enrollment. Be sure dependents listed agree with the level of coverage selected in sections 2b. List the name, date of birth, gender, and Social Security number of the family members you wish to be covered under the plan. You may list an eligible spouse, civil union partner, or same-sex domestic partner, and your children under age 26.

SPOUSE: This is a person of the opposite sex to whom you are legally married. A photocopy of the *Marriage Certificate* and a photocopy of the employee's most recent Federal tax return* that includes the spouse are required for enrollment.

CIVIL UNION PARTNER: This is a person of the same sex with whom you have entered into a civil union. A photocopy of the *New Jersey Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions and a photocopy of the employee's most recent NJ tax return* that includes the partner are required for enrollment. The cost of civil union partner coverage may be subject to federal tax (see your employer or Fact Sheet #75, *Civil Unions*, for details).

DOMESTIC PARTNER: This is a same-sex domestic partner, as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act, of any State employee, State retiree, or an eligible employee or retiree of a SHBP or SEHBP participating local public entity if the local governing body adopts a resolution to provide Chapter 246 health benefits. A photocopy of the *New Jersey Certificate of Domestic Partnership* dated prior to February 19, 2007 or a valid certification from another jurisdiction that recognizes same-sex domestic partners and a photocopy of the employee's most recent NJ tax return* that includes the partner are required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer or Fact Sheet #71, *Benefits Under the Domestic Partnership Act*, for details).

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

CHILDREN: This is your child under age 26. A photocopy of a child's birth certificate showing the name of the employee as a parent is required for enrollment. In addition, if you have listed a child who is an adopted child, foster child, stepchild, legal ward, has a different last name than the employee, or if the member has a Parent/Child contract, additional supporting documentation is required. A child is only eligible if he or she is **not** eligible to enroll in other employer-based coverage (aside from coverage through the parent). If you have more than four eligible dependent children, attach a separate application and complete Sections 1, 3, and 5. For all dependents, include the dentist's name or identification number. All dependents must have this information listed. Refer to the DPO directory for this information or call the dental plan directly.

NOTE: If you are deleting dependents, do not list them in this section. Refer to section 4b and 4c.

SECTION 4 - TYPE OF ACTIVITY

4a. If you are adding a dependent, check the appropriate box, indicate the event date, and attach required proof of dependency documentation.

4b. If you are deleting a dependent spouse, civil union partner, or domestic partner, check reason and indicate the event date.

4c. If you are deleting a dependent child, indicate the event date, list the child's Social Security number, and give reason.

4d. For other changes, check the appropriate box, give requested information, and attach a copy of supporting documentation if applicable.

SECTION 5 - EMPLOYEE CERTIFICATION

You must read the Employee Certification statement, **sign it, and date the application.**

Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

EMPLOYER CERTIFICATION

Must be completed by your employer before submitting the application. By signing this application the employer certifies that:

- 1) The employee is eligible;
- 2) The application is legible and completed in its entirety;
- 3) The employee's selected plans and coverage levels are appropriate;
- 4) The Employer Certification section is completed in its entirety; and
- 5) The information presented is true to the best of their knowledge.

REQUIRED DOCUMENTATION FOR SHBP/SEHBP DEPENDENT ELIGIBILITY AND ENROLLMENT

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

DEPENDENTS	ELIGIBILITY DEFINITION	DOCUMENTATION REQUIRED
SPOUSE	A person of the opposite sex to whom you are legally married.	<ul style="list-style-type: none"> • A photocopy of the <i>Marriage Certificate</i> and • A photocopy of the front page of the employee/retiree's most recently filed federal tax return* (<i>Form 1040</i>) that includes the spouse.
CIVIL UNION PARTNER	A person of the same sex with whom you have entered into a civil union.	<ul style="list-style-type: none"> • A photocopy of the <i>New Jersey Civil Union Certificate</i> or a valid certification from another jurisdiction that recognizes same-sex civil unions and • A photocopy of the front page of the employee/retiree's most recently filed NJ tax return* that includes the partner or a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partner's and is received at the same address.
DOMESTIC PARTNER	A person of the same sex with whom you have entered into a domestic partnership as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act. The domestic partner of any State employee, State retiree, or any eligible employee or retiree of a SHBP/SEHBP participating local public entity, who adopts a resolution to provide Chapter 246 health benefits, is eligible for coverage.	<ul style="list-style-type: none"> • A photocopy of the <i>New Jersey Certificate of Domestic Partnership</i> dated prior to February 19, 2007 or a valid certification from another State of foreign jurisdiction that recognizes same-sex domestic partners and • A photocopy of the front page of the employee/retiree's most recently filed NJ tax return* that includes the partner or a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partner's and is received at the same address.
CHILDREN	A subscriber's child until age 26, <i>regardless</i> of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his or her parents. This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation. Coverage until age 26 is only available if an adult child is <u>not</u> eligible to enroll in other employer-based coverage (aside from coverage through the parent).	<ul style="list-style-type: none"> • Natural or Adopted Child – A photocopy of the child's birth certificate showing the name of the employee/retiree as a parent. • Step Child – A photocopy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent and a photocopy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner. • Legal Guardian, Grandchild, or Foster Child – Photocopies of Final Court Orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the covered employee.

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

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

REQUIRED DOCUMENTATION FOR SHBP/SEHBP DEPENDENT ELIGIBILITY AND ENROLLMENT

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

DEPENDENTS	ELIGIBILITY DEFINITION	DOCUMENTATION REQUIRED
<p>DEPENDENT CHILDREN WITH DISABILITIES</p>	<p>If a covered child is not capable of self-support when he or she reaches age 26 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuance of coverage. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP or SEHBP, and (2) the child continues to be disabled, and (3) the child is unmarried or does not enter into a civil union or domestic partnership, and (4) the child remains substantially dependent on you for support and maintenance. You will be contacted periodically to verify that the child remains eligible for continued coverage.</p>	<ul style="list-style-type: none"> • Documentation for the appropriate "Child" type as noted on page 1 and a photocopy of the front page of the employee/retiree's most recently filed federal tax return* (<i>Form 1040</i>) that includes the child. • If Social Security disability has been awarded, or is currently pending, please include this information with the documentation that is submitted. <p>Please note that this information is only verifying the child's eligibility as a dependent. The disability status of the child is determined through a separate process.</p>
<p>CONTINUED COVERAGE FOR OVER AGE CHILDREN</p>	<p>Certain children over age 26 may be eligible for continued coverage until age 31 under the provisions of Chapter 375, P.L. 2005.</p> <p>This includes a child by blood or law who:</p> <ul style="list-style-type: none"> • Is under the age of 31; • Is unmarried or not a partner in a civil union or domestic partnership; • Has no dependent(s) of his or her own; • Is a resident of New Jersey or is a student at an accredited public or private institution of higher education, with at least 15 credit hours; and • Is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or health benefits plan, or entitled to benefits under Medicare. 	<ul style="list-style-type: none"> • Documentation for the appropriate "Child" type as noted on page 1 and a photocopy of the front page of the child's most recently filed federal tax return* (<i>Form 1040</i>), and if the child resides outside of the State of New Jersey, documentation of full time student status must be submitted.

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

To obtain copies of the documents listed above, contact the office of the Town Clerk in the city of the birth, marriage, etc., or visit these Web sites: www.vitalrec.com or www.studentclearinghouse.org

New Jersey residents can obtain records from the State Bureau of Vital Statistics and Registration Web site: www.state.nj.us/health/vital/index.shtml