

STATE OF NEW JERSEY



CIGNA HEALTHCARE

MEMBER HANDBOOK

**FOR EMPLOYEES AND RETIREES
ENROLLED IN THE
STATE HEALTH BENEFITS PROGRAM OR
SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM**

PLAN YEAR 2011

Welcome!

Our goal is your good health. To achieve this goal, we encourage preventive care in addition to covering you when you are sick or injured. An extensive network of participating physicians and hospitals is available to provide you with easy access to medical care 24 hours a day, 7 days a week.

We believe that through the appropriate use of health resources, we can work together to keep you healthy and to control the rising costs of medical care for everyone.

Your Health Maintenance Organization (HMO) benefits program is self-funded by your employer and administered by CIGNA Health Plans Inc. (CIGNA).

An online version of this handbook containing current updates is available on the Division of Pensions and Benefits Web site:

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

Be sure to check the Web site for related forms, fact sheets, and news of any developments affecting the benefits provided under the State Health Benefits Program (SHBP) or the School Employees' Health Benefits Program (SEHBP).

*Every effort has been made to ensure the accuracy of the CIGNA Member Handbook, which describes the benefits provided and is an amendment to the contract with CIGNA. However, State law and the New Jersey Administrative Code govern the SHBP and the SEHBP. **If there are discrepancies between the information presented in this handbook, and the law, regulations, or contract, the latter will govern.***

We wish you the best of health.

How to Use Your Plan

This member handbook is your guide to the benefits available through CIGNA HealthCare. Please read it carefully and refer to it when you need information about how the Plan works, to determine what to do in an emergency situation, and what benefits are covered. It is also an excellent source for learning about many of the special programs available to you as a Plan participant.

If you cannot find the answer to your question(s) in the member handbook, call the Member Services toll-free number on your identification card (ID). A trained representative will be happy to help you. For more information, go to the “Member Services” section later in this book.

Tips for New Plan Participants

- Keep this member handbook where you can easily refer to it.
- Keep your ID card(s) in your wallet and sign up for: myCIGNA.com.
- Post your Primary Care Physician’s name and number near the telephone.
- Emergencies are covered anytime, anywhere, 24 hours a day. See “In Case of Medical Emergency” for emergency care guidelines.

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How the Plan Works

Plan participants have access to a network of participating Primary Care Physicians, specialists and hospitals that meet CIGNA's requirements for quality and service. These providers are independent physicians and facilities that are monitored for quality of care, patient satisfaction, cost-effectiveness of treatment, office standards and ongoing training.

Each participant in the Plan must select a Primary Care Physician when they enroll. Your Primary Care Physician serves as your guide to care in today's complex medical system and will help you access appropriate care.

The Primary Care Physician

As a participant in the Plan, you will become a partner with your participating Primary Care Physician in preventive medicine. Consult your Primary Care Physician whenever you have questions about your health. Your Primary Care Physician will provide your care and will refer you to specialists or facilities for treatment when medically necessary. The referral is important because it is how your Primary Care Physician arranges for you to receive necessary, appropriate care and follow-up treatment. **You must have a prior referral from your Primary Care Physician to receive coverage for any services the specialist or facility provides** except for PCP, direct access, routine services and emergencies. Participating specialists are required to send reports back to your Primary Care Physician to keep your Primary Care Physician informed of any treatment plans ordered by the specialist.

Primary and Preventive Care

Your Primary Care Physician can provide preventive care and treat you for illnesses and injuries. The Plan covers routine physical exams, well-baby care, immunizations and allergy shots provided by your Primary Care Physician. You may also obtain routine gynecological exams from participating providers without a referral from your Primary Care Physician. You are responsible for the applicable copayment.

Specialty and Facility Care

Your Primary Care Physician may refer you to a specialist or facility for treatment or for covered preventive care services, when medically necessary. **You must have a prior referral from your Primary Care Physician to receive coverage for any services the specialist or facility provides** except for direct access benefits (routine gynecological exams, routine eye exams and Chiropractic Services) and emergency services. When your Primary Care Physician refers you to a participating specialist or facility for covered services, you will be responsible for the applicable copayment. To avoid costly and unnecessary bills, follow these steps:

- **Consult your Primary Care Physician first** when you need routine medical care. If your Primary Care Physician deems it medically necessary, you will get a written or electronic referral to a participating specialist or facility. Referrals are valid for 90 days, as long as you remain an eligible participant in the Plan.
- Certain services require **both** a referral from your Primary Care Physician **and** prior authorization from CIGNA.

Your Primary Care Physician is responsible for obtaining authorization from CIGNA for in-network covered services.

- **Review the referral** with your Primary Care Physician. Understand what specialist services are being recommended and why.
- Present the referral to the participating provider. The referral is necessary to have these services approved for payment. **Without the referral, you are responsible for payment for these services.**
- If it is not an emergency and you go to a doctor or facility **without your** Primary Care Physician's **prior referral; you must pay the bill yourself.**
- Your Primary Care Physician may refer you to a nonparticipating provider for covered services that are not available within the network. Services from nonparticipating providers require prior approval by CIGNA in addition to a special nonparticipating referral from your Primary Care Physician. When properly authorized, these services are covered after the applicable copayment.

Remember: You cannot request referrals **after** you visit a specialist or hospital. Therefore, to receive maximum coverage, you need to contact your Primary Care Physician and get authorization from CIGNA (when applicable) **before** seeking specialty or hospital care.

Provider Information

You may obtain, without charge, information about network providers from your Plan Administrator, or by calling the toll free Member Services number on your ID card.

Your ID Card

When you join the Plan, you and each enrolled member of your family receive a member ID card. Always carry your ID card with you. It identifies you as a Plan participant when you receive services from participating providers or when you receive emergency services at nonparticipating facilities. If your card is lost or stolen, please notify CIGNA immediately.

Transition of Care

Transition of Care benefits allow patients who have certain medical conditions to continue their treatment with non-participating physicians for a certain period of time determined by CIGNA HealthCare. This allows continued uninterrupted care until safe transfer of care to a participating physician can be arranged. You and your covered dependents may be eligible for Transition of Care when you are a newly enrolled CIGNA HealthCare member, or if your participating provider leaves the CIGNA HealthCare network. To find out more about this program, call Member Services at the toll-free number on your CIGNA HealthCare ID card.

Copayment Schedule

Unless otherwise indicated in the chart below, the **copayment for State employees is \$15** per visit to a Primary Care Physician or referred specialist or facility.

The **copayment for Local Government, and Local Education employees, and all Retirees is \$10** per visit to a Primary Care Physician or referred specialist or facility.

All non-emergency specialty and hospital services require a prior referral from your Primary Care Physician, unless noted below as a “direct access” benefit.

Type of Service or Supply

Benefit Level

Maximum Benefit

Unlimited

Maximum Out-of-Pocket (Per Calendar Year)

Individual

None

Family

None

Primary and Preventive Care

PCP Office Visits

Copayment applies per visit

After Hours/Home Visits/Emergency Visits

Copayment applies per visit

Routine Examinations

Copayment applies per visit

Routine Child and Well-Baby Care

Copayment applies per visit

Immunizations

Copayment applies per visit

Inpatient Visits

No copayment

Routine Gynecological Exams – direct access
(no referral) to participating provider.

Unlimited visit per calendar year

Copayment applies per visit

Routine Mammogram – one annual
mammogram for women age 40 and over

No copayment

Prostate Screening – one annual prostate
screening for men age 40 and over

Copayment applies per visit

Hearing Aids

Not covered– except for members
15 years old or younger

Specialty and Outpatient Care

Specialist Office Visits

Copayment applies per visit

Prenatal Care – for the first OB visit

Copayment applies per visit

Subsequent Prenatal Visits

No copayment

Infertility Services:

Diagnosis

Copayment applies per visit

Treatment: with limitations

Copayment applies per visit

Advanced Reproductive Technology

Copayment applies per visit

Allergy Testing

Copayment applies per visit

Allergy Treatment – routine injections at PCP’s
office, with or without physician encounter

Copayment applies per visit
or the actual charge whichever is less

Outpatient Facility Visits

No copayment

Chemotherapy

No copayment

Type of Service or Supply**Benefit Level**

Radiation Therapy	No copayment
Infusion Therapy	Copayment applies per visit
X-rays and Lab Tests performed at a Hospital Outpatient Facility	No copayment
Outpatient Rehabilitation (Other than Physical Therapy, Occupational Therapy, Speech Therapy and Cardiac Rehabilitation)	No copayment
60 visits combined for all outpatient rehabilitation therapies per calendar year	
Outpatient Therapy (Speech, Occupational, Physical)	Copayment applies per visit
60 visits per condition with the first day of treatment per calendar year	
Outpatient Cardiac Rehabilitation Therapy	Copayment applies per visit
Chiropractic Care	Copayment applies per visit
20 visits per calendar year	
Home Health Care	No copayment
Hospice Care	No copayment
Durable Medical Equipment (DME)	\$100 deductible per calendar year which is combined with EPA
DME Out-of-Pocket Maximum	None
External Prosthetic Devices (EPA)	\$100 deductible per calendar year which is combined with DME
EPA Out-of-Pocket Maximum	None

(DME and Prostheses must be approved in advance by CIGNA)

Inpatient Services

Hospital Room and Board and other Inpatient Services	No copayment
Skilled Nursing Facilities Up to 120 days per calendar year	No copayment
Hospice Facility	No copayment

Surgery and Anesthesia

Inpatient Surgery	No copayment
Outpatient Surgery	No copayment

Mental and Nervous Conditions

Inpatient Treatment: Mental Illness	No copayment
Maximum of 35 days per calendar year	
Outpatient Treatment: Mental Illness	Copayment applies per visit
30 visits per calendar year	

Type of Service or Supply	Benefit Level
Treatment of Alcohol and Drug Abuse	
Inpatient Treatment – up to 28 days per occurrence	No copayment
Inpatient Detoxification	No copayment
Outpatient Treatment – 60 visits per calendar year	No copayment
Inpatient Rehabilitation – up to 28 days per occurrence	No copayment
Outpatient Detoxification	No copayment
Maternity	No copayment
Emergency Care	
Hospital Emergency Room copayment waived if admitted	\$ 50 copayment for State employees \$ 35 copayment for Local employees and all Retirees
Urgent Care Facility	\$ 35 copayment
Ambulance	No copayment
Vision Benefits	
Routine Eye Exam every 12 months	Copayment applies
HMO Prescription Drug Plan (Employees) – no annual maximum	
Retail (30-day supply)	\$ 5 copayment – generic drugs \$ 10 copayment – brand-name formulary drugs \$ 20 copayment – brand non-formulary drugs
Mail Order (90-day supply)	\$ 5 copayment – generic drugs \$ 15 copayment – brand-name formulary drugs \$ 25 copayment – brand non-formulary drug
<i>(Prescription coverage through the HMO Prescription Drug Plan may not be applicable to all employees)</i>	
HMO Prescription Drug Plan (State and Local Government Retirees)	
Retail (30-day supply)	\$ 6 copayment – generic drugs \$ 12 copayment – brand-name formulary drugs \$ 24 copayment – brand non-formulary drugs
Mail Order (90-day supply)	\$ 6 copayment – generic drugs \$ 18 copayment – brand-name formulary drugs \$ 30 copayment – brand non-formulary drugs
Annual Maximum Out-of-Pocket	\$ 1,351 per person
HMO Prescription Drug Plan (Local Education Retirees)	
Retail (30-day supply)	\$ 5 copayment – generic drugs \$ 12 copayment – brand-name formulary drugs \$ 24 copayment – brand non-formulary drugs
Mail Order (90-day supply)	\$ 6 copayment – generic drugs \$ 17 copayment – brand-name formulary drugs \$ 29 copayment – brand non-formulary drugs
Annual Maximum Out-of-Pocket	\$ 1,318 per person

Your Benefits

Although a specific service may be listed as a covered benefit, it may not be covered unless it is medically necessary for the prevention, diagnosis or treatment of your illness or condition. Refer to the “Glossary” section for the definition of “medically necessary.”

Certain services must be pre-certified by CIGNA. Your participating provider is responsible for obtaining this approval.

Primary and Preventive Care

One of the Plan’s goals is to help you maintain good health through preventive care. Routine exams, immunizations and well-child care contribute to good health and are covered by the Plan (after any applicable copayment) if provided by your Primary Care Physician or on referral from your Primary Care Physician.

Primary and Preventive services include:

- Office visits with your Primary Care Physician
- Home visits by your Primary Care Physician.
- Treatment for illness and injury.
- Routine physical examinations (including, but is not limited to, employer-mandated physical examinations that are prerequisite to participation in a physical fitness test that is required as a condition of continuing employment).
- Well-child care from birth, including immunizations and booster doses
- Health education counseling and information.
- Annual prostate screening (PSA) and digital exam for males age 40 and over, and for males considered to be at high risk who are under age 40.
- Routine gynecological examinations and Pap smears performed by your Primary Care Physician. You may also visit a participating gynecologist for a routine GYN exam and Pap smear without a referral.
- Annual mammography screening for asymptomatic women age 40 and older. Annual screening is covered for younger women who are judged to be at high risk by their Primary Care Physician.

Note: Diagnostic mammography for women with signs or symptoms of breast disease is covered as medically necessary.

- Routine immunizations (except those required for travel or work).
- Periodic eye examinations. You may visit a participating provider without a referral once every 12 months.
- Routine hearing screenings performed by your Primary Care Physician as part of a routine physical examination.

Specialty and Outpatient Care

The Plan covers the following specialty and outpatient services. You must have a prior written or electronic referral from your Primary Care Physician in order to receive coverage for any non-emergency services the specialist or facility provides.

- Participating specialist office visits.
- Participating specialist consultations, including second opinions.
- Outpatient surgery for a covered surgical procedure when furnished by a participating outpatient surgery center. All outpatient surgery must be approved in advance by CIGNA.
- Preoperative and postoperative care.
- Casts and dressings.
- Radiation therapy.
- Cancer chemotherapy.
- Routine costs of care for patients enrolled in Phase I, II, and III cancer clinical trials. This coverage includes costs associated with the administration of the drugs, such as hospitalization, outpatient visits, doctors' fees, lab tests, etc.
- Short-term speech, occupational (except vocational rehabilitation and employment counseling), and physical therapy for treatment of non-chronic conditions and acute illness or injury.
- Autism or another developmental disability – Effective February, 8, 2010, Chapter 115, P.L. 2009, requires that the SHBP/SEHBP provide:
 - Coverage for expenses incurred in screening and diagnosing autism or another developmental disability;
 - Coverage for expenses incurred for medically necessary physical therapy, occupational therapy and speech therapy services for the treatment of autism or another developmental disability;
 - Coverage for expenses incurred for medically necessary behavioral interventions (ABA therapy) for individuals under 21 years of age diagnoses with autism;
 - A benefit for the Family Cost Share portion of expenses incurred for certain health care services obtained through the New Jersey Early Intervention System (NJEIS).

There is a \$36,000 dollar benefit maximum for ABA therapy services per year for children with autism. ABA therapy is not eligible for children with developmental diagnoses.

CIGNA Behavioral Health must be contacted to precertify ABA services for autistic children.

CIGNA HealthCare Utilization Management must be contacted for precertification by the provider requesting occupational therapy, speech, and physical therapy services.

- Inherited Metabolic Diseases – Coverage for the therapeutic treatment of inherited metabolic diseases when diagnosed by a Physician and deemed to be medically necessary. Treatment includes the purchase of medical foods and low protein modified food products. Inherited metabolic diseases means a disease caused by an inherited abnormality of body chemistry. A

low protein modified food product is one that is specially formulated to have less than one gram of protein per serving. It is intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease, but does not include a (natural) food that is naturally low in protein.

Medical food means one that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under the direction of a Physician.

- Cognitive therapy associated with physical rehabilitation for treatment of non-chronic conditions and acute illness or injury.
- Short-term cardiac rehabilitation provided on an outpatient basis following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Short-term pulmonary rehabilitation provided on an outpatient basis for the treatment of reversible pulmonary disease.
- Diagnostic, laboratory and X-ray services.
- Emergency care including ambulance service – 24 hours a day, 7 days a week (see “In Case of Emergency”).
 - Hearing Aids – Effective March 30, 2009, coverage will be provided for medically necessary expenses incurred in the purchase of a hearing aid for covered members who are 15 years old or younger. Coverage is provided for the purchase of a hearing aid for each hearing impaired ear once in a 24 month period, when it is medically necessary and prescribed by a licensed physician or audiologist. Benefits during each 24 month period are limited to the cost of the hearing aid up to \$1,000 for each hearing impaired ear. If a higher priced hearing aid is selected, the member is responsible for the amount that is greater than \$1,000.
- Home health services provided by a participating home health care agency, including:
 - Skilled nursing services provided or supervised by an RN.
 - Services of a home health aide for skilled care.
 - Medical social services provided or supervised by a qualified physician or social worker if your Primary Care Physician certifies that the medical social services are necessary for the treatment of your medical condition.
- Outpatient hospice services include:
 - Counseling and emotional support.
 - Home visits by nurses and social workers.
 - Pain management and symptom control.
 - Instruction and supervision of a family member.
- Oral surgery (limited to extraction of bony, impacted teeth, treatment of bone fractures, removal of tumors and odontogenic cysts).
- Accidental dental injuries if medically necessary. You must have been covered by CIGNA at the time the injury occurred. An accidental dental injury is considered an injury to teeth (must be sound natural teeth) which is caused by an external factor such as damage caused by being

hit by a hockey puck or having teeth broken in a fall on the ice. The treatment and replacement must occur within 12 months of the accident. A treatment plan must be submitted. If it is determined that treatment cannot be reasonably completed within 12 months, this time limit may be extended. Breaking a tooth while chewing on food is not considered an accidental dental injury. Stress fractures in teeth are very common and generally undetectable by X-ray. Stress fractures are often the cause of tooth breakage. Treatment for this type of tooth breakage is considered a dental service and not eligible for reimbursement.

- Reconstructive breast surgery following a mastectomy, including:
 - Reconstruction of the breast on which the mastectomy is performed, including areolar reconstruction and the insertion of a breast implant,
 - Surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed, and
 - Physical therapy to treat the complications of the mastectomy, including lymphedema.
- Chiropractic services. Subluxation services must be consistent with CIGNA’s guidelines for spinal manipulation to correct a muscular skeletal problem or subluxation that is documented by diagnostic X-rays.
- Prosthetic appliances and orthopedic braces (including repair and replacement when due to normal growth). Prosthetics require preauthorization by CIGNA.
- Durable medical equipment (DME), prescribed by a physician for the treatment of an illness or injury, and preauthorized by CIGNA.

The Plan covers instruction and appropriate services required for the Plan participant to properly use the item, such as attachment or insertion, if approved by CIGNA.

Replacement, repair and maintenance are covered only if:

- They are needed due to a change in your physical condition, or
- Replacement is covered if it is likely to cost less than to repair the existing equipment or to rent similar equipment.

The request for any type of DME must be made by your physician, pre-authorized and coordinated through the CIGNA Patient Management Department.

Inpatient Care in a Hospital, Skilled Nursing Facility, or Hospice

If you are hospitalized by a participating Primary Care Physician or specialist (with prior referral except in emergencies), you are eligible for the following covered services listed below. See “Behavioral Health” for inpatient mental health and substance abuse benefits.

- Confinement in semi-private accommodations (or private room when medically necessary and certified by your Primary Care Physician) while confined to an acute care facility.
- Confinement in semi-private accommodations in an extended care/skilled nursing facility.
- Confinement in semi-private accommodations in a hospice care facility for a Plan participant who is diagnosed as terminally ill.

Note: The Plan does **not** cover the following hospice services:

- Funeral arrangements, or financial or legal counseling.
- Homemaker or caretaker services and any service not solely related to the medical care of the terminally ill patient.
- Respite care when the patient’s family or usual caretaker cannot, or will not, attend to the patient’s needs.
- Use of intensive or special care facilities.
- Visits by your Primary Care Physician while you are confined.
- General nursing care.
- Surgical, medical and obstetrical services provided by the participating hospital.
- Use of operating rooms and related facilities.
- Application of medical and surgical dressings, supplies, casts and splints.
- Drugs and medications.
- Intravenous injections and solutions.
- Administration and processing of blood, processing fees and fees related to autologous blood donations. (The blood or blood product itself is not covered if it has been donated or replaced on behalf of the patient.)
- Nuclear medicine.
- Preoperative care and postoperative care.
- Anesthesia and anesthesia services.
- Oxygen and oxygen therapy.
- Inpatient physical and rehabilitation therapy, including:
 - Cardiac rehabilitation, and
 - Pulmonary rehabilitation.
- X-rays (other than dental X-rays), laboratory testing and diagnostic services.
- Use of Magnetic Resonance Imaging.
- Transplant services are covered if the transplant is not experimental or investigational and has been approved in advance by CIGNA. Transplants must be performed in hospitals specifically approved and designated by CIGNA.

Maternity

The Plan covers physician and hospital care for mother and baby, including prenatal care, delivery and postpartum care. In accordance with the Newborn and Mothers Healthcare Protection Act, you and your newly born child are covered for a minimum of 48 hours of inpatient care following a vaginal delivery (96 hours following a cesarean section). However, your provider may – **after consulting with you** – discharge you earlier than 48 hours after a vaginal delivery (96 hours following a cesarean section).

Note: If you are pregnant at the time you join the Plan, you receive coverage for authorized care from participating providers **on and after your effective date of enrollment**. Coverage for services incurred prior to your effective date with the Plan is your responsibility or that of your previous plan.

Infertility Treatment

CIGNA will follow the New Jersey State Mandate for Infertility.

Charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy (including microsurgical sperm aspiration); laboratory tests; sperm washing or preparation; diagnostic evaluations; assisted hatching; fresh and frozen embryo transfer; ovulation induction; gamete intrafallopian transfer (GIFT); in vitro fertilization (IVF), including in vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier; zygote intrafallopian transfer (ZIFT); artificial insemination; intracytoplasmic sperm injection (ICSI); and the services of an embryologist. This benefit includes diagnosis and treatment of both male and female infertility.

Eligibility Requirements

Infertility services are covered for any abnormal function of the reproductive systems such that you are not able to:

- Impregnate another person;
- Conceive after two years if the female partner is under 35 years old, or after one year if the female partner is 35 years old or older, or if one partner is considered medically sterile; or
- Carry a pregnancy to live birth.

In vitro fertilization, gamete transfer and zygote transfer services are covered only:

- If you have used all reasonable, less expensive and medically appropriate treatment and are still unable to become pregnant or carry a pregnancy;
- Up to four completed egg retrievals combined, per lifetime (including those covered under prior plans, but not those provided at your expense); and
- If you are 45 years old or younger.

Covered Expenses

- Where a live donor is used in the egg retrieval, the medical costs of the donor shall be covered until the donor is released from treatment by the reproductive endocrinologist;
- Egg retrievals where the cost was not covered by any carrier shall not count in determining whether the four completed egg retrieval limit has been met;
- Intracytoplasmic sperm injections;
- In vitro fertilization, including in vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational;

- Prescription medications, including injectable infertility medications, are covered under the SHBP/SEHBP's Prescription Drug Plans. Private freestanding prescription drug plans arranged by local employer groups are required to be comparable to the SHBP/SEHBP Prescription Drug Plans and must provide coverage for infertility medications for covered members and donors;
- Ovulation induction;
- Surgery, including microsurgical sperm aspiration;
- Artificial Insemination;
- Assisted Hatching;
- Diagnosis and diagnostic testing; and
- Fresh and frozen embryo transfers.

Exclusions

The following are specifically excluded infertility services:

- Reversal of male and female voluntary sterilization;
- Infertility services when the infertility is caused by or related to voluntary sterilization;
- Non-medical costs of an egg or sperm donor. Medical costs of donors, including office visits, medications, laboratory and radiological procedures and retrieval, shall be covered until the donor is released from treatment by the reproductive endocrinologist;
- Cryopreservation is not a covered benefit;
- Any experimental, investigational, or unproven infertility procedures or therapies.
- Payment for medical services rendered to a surrogate for purposes of childbearing where the surrogate is not covered by the carrier's policy or contract;
- Ovulation kits and sperm testing kits and supplies; or
- In vitro fertilization, gamete intrafallopian tube transfer, and zygote intrafallopian tube transfer for persons who have not used all reasonable less expensive and medically appropriate treatments for infertility, who have exceeded the limit of four covered completed egg retrievals, or are 46 years of age or older.

Behavioral Health

Your mental health/substance abuse benefits will be provided by participating behavioral health providers. You do not need a referral from your Primary Care Physician to obtain care from participating mental health and substance abuse providers. Instead, when you need mental health or substance abuse treatment, call the behavioral health telephone number shown on your ID card. A clinical care manager will assess your situation and refer you to participating providers, as needed.

Mental Health Treatment

The Plan covers the following services for mental health treatment:

- **Inpatient** medical, nursing, counseling and therapeutic services in a hospital or non-hospital residential facility, appropriately licensed by the Department of Health or its equivalent.
- Short-term evaluation and crisis intervention mental health services provided on an **outpatient** basis.

Treatment of Alcohol and Drug Abuse

The Plan covers the following services for treatment of alcohol and drug abuse subject to Plan maximums:

- **Inpatient** care for detoxification, including medical treatment and referral services for substance abuse or addiction.
- **Inpatient** medical, nursing, counseling and therapeutic rehabilitation services for treatment of alcohol or drug abuse or dependency in an appropriately licensed facility.
- **Outpatient** visits for substance abuse detoxification. Benefits include diagnosis, medical treatment and medical referral services by your Primary Care Physician.
- **Outpatient** visits to a participating behavioral health provider for diagnostic, medical or therapeutic rehabilitation services for substance abuse.

Outpatient treatment for substance abuse or dependency must be provided in accordance with an individualized treatment plan.

Prescription Drugs

The State Health Benefits Commission and School Employees' Health Benefits Commission require that all covered employees and retirees have access to prescription drug coverage.

The Commissions reserve the right to establish dispensing limits on any medication based on Food and Drug Administration (FDA) recommendations and medical appropriateness. Prior Authorization, Drug Utilization Review, Dose Optimization, Step Therapy, and the Specialty Pharmacy Program may be employed to ensure that the medications that are reimbursed under the plan are the most clinically appropriate and cost effective. Volume restrictions currently apply to certain drugs such as sexual dysfunction drugs (Viagra, Muse, etc.).

Medicare Part D

The prescription drug benefits provided through the SHBP and SEHBP are equal to or better than the benefits provided by the standard Medicare Part D plan. Therefore, most Medicare eligible retirees and/or Medicare eligible dependents need not enroll in Medicare Part D prescription drug coverage. While some SHBP or SEHBP members who qualify for low income subsidy programs may find it beneficial to enroll in Medicare Part D, once you and/or a dependent enroll in a Medicare Part D plan, the person enrolled in Medicare Part D will lose their SHBP or SEHBP prescription drug coverage. In addition, the SHBP and SEHBP will not cover the costs of any drugs that are not covered by the Medicare Part D plan.

Employee Prescription Drug Plan

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

The Employee Prescription Drug Plan is administered by Medco Health Solutions, Inc.

For more information about the Employee Prescription Drug Plan, copayment amounts, and specific benefits, see the *Employee Prescription Drug Plan Member Handbook* which is available at the SHBP/SEHBP home page at: www.state.nj.us/treasury/pensions/health-benefits.shtml

HMO Prescription Drug Plan Administered by Medco

- **If you are employed by a county, municipality, board of education, or other local public employer that does not provide a separate prescription drug plan — or you are a retiree — you will be enrolled in the HMO Prescription Drug Plan.**
- **If you are eligible for prescription drug coverage through a separate drug plan provided by your employer, you will not be provided prescription drug coverage and any prescription drug copayments from other group plans will not be reimbursed through CIGNA HealthCare.**

Plan Benefits (For Employees without a separate prescription drug plan and All Retirees)

The HMO Prescription Drug Plan pays, subject to any limitations specified in this section, the cost incurred for outpatient prescription drugs that are obtained from a participating pharmacy. You must present your ID card and make the copayment shown in the “Copayment Schedule” for each prescription at the time the prescription is dispensed.

Retail prescription is limited to a maximum 30-day supply, with refills as authorized by your physician (but not to exceed one year from the date originally prescribed). Non-emergency prescriptions must be filled at a participating pharmacy. Generic drugs may be substituted for brand-name products where permitted by law.

Coverage is based upon Medco’s formulary. The formulary includes both brand-name and generic drugs and is designed to provide access to quality, affordable outpatient prescription drug benefits. You can reduce your copayment by using a covered generic or brand-name drug that appears on the formulary. Your copayment will be highest if your physician prescribes a covered brand-name drug that does not appear on the formulary.

Mail Order Drugs

Participants in the HMO Prescription Drug Plan who must take a drug for more than 30 days may obtain up to a 90-day supply of the drug through the Medco mail order pharmacy, if authorized by their physician. The minimum quantity dispensed by a mail order pharmacy is for a 31-day supply, and the maximum quantity is for a 90-day supply. The copayment shown in the “Copayment Schedule” will apply to each mail order purchase.

Emergency Prescriptions

You may not have access to a participating pharmacy in an emergency or urgent care situation, or if you are traveling outside of the HMO Prescription Drug Plan’s service area. You will need to

mail a claim form within one year of the prescription fill date, along with original receipts (not cash register receipts).

Participating Pharmacy

When you obtain an emergency or urgent care prescription at a participating pharmacy (including an out-of-area participating pharmacy), you must pay the copayment.

Specialty Pharmacy Network Benefits

Medco's specialty pharmacy, Accredo, will provide up to a 90-day supply of your specialty medication as prescribed and when appropriate.

Self-injectable drugs are covered at the network level of benefits only when dispensed through Accredo. Refer to the preferred drug guide for a list of self-injectable drugs.

- Specialty pharmacy services are provided through Accredo Specialty Pharmacy which is the exclusive provider for specialty pharmaceuticals for the SHBP and SEHBP. Specialty pharmaceuticals are a class of medications that are typically produced through biotechnology, administered by injection, and/or require special patient monitoring and handling. If your doctor has prescribed a specialty pharmaceutical, you will not be able to fill the prescription at a retail pharmacy. If you try to fill a specialty prescription at a retail pharmacy, the pharmacy representative will advise you to contact Accredo at 1-800-501-7260. When calling, identify yourself as a SHBP or SEHBP member. Accredo will contact your doctor and take care of the appropriate paperwork. Your medication will be shipped directly to your home, office, or doctor's office.

The initial prescription for a self-injectable drug must be filled at a network retail pharmacy or at Medco's specialty pharmacy. All subsequent prescription drug refills for self-injectable drugs must be obtained through Medco's specialty pharmacy. Only one fill at a network retail pharmacy is covered. Future prescriptions must be filled through Medco's specialty pharmacy.

Utilization Review for Prescription Drugs

As with medical services, all prescription drugs will be subject to utilization review and the health plan reserves the right to establish dispensing limits on any medication based on Food and Drug Administration (FDA) recommendations and medical appropriateness. Prior Authorization, Drug Utilization Review, Dose Optimization and Step Therapy may be employed to ensure that the medications that are reimbursed under the plan are the most clinically appropriate and cost effective. Volume restrictions may apply to certain drugs.

Covered Drugs

The HMO Prescription Drug Plan covers the following:

- Outpatient FDA-approved prescription drugs when prescribed by a provider who is licensed to prescribe federal legend drugs or medicines, subject to the terms, limitations and exclusions described in this member handbook.
- Off-label use of FDA-approved prescription drugs provided that:
 - The drug is recognized for treatment of the condition in question in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American

Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information), or

– The safety and effectiveness of use for the condition has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal.

- Diabetic supplies, as follows:
 - Diabetic needles and syringes.
 - Alcohol swabs.
 - Test strips for glucose monitoring and/or visual reading.
 - Diabetic test agents.
 - Lancets (and lancing devices).
- Contraceptives and contraceptive devices, as follows:
 - Oral contraceptives.
 - Up to 5 vials of Depo-Provera in a 365 consecutive-day period. A separate copayment applies to each vial.
 - IUDs are covered when obtained from your Primary Care Physician or participating Ob/Gyn. The office visit copayment will apply when the device is inserted and removed.
- Drugs prescribed to aid or enhance sexual performance, including sildenafil citrate, phentolamine, apomorphine and alprostadil in oral and topical (including but not limited to gels, creams, ointments and patches) forms. Coverage is limited to a total of no more than 4 pills, 6 units/vials or other forms (in unit amounts determined by Medco to be similar in cost to oral forms) per 30-day supply. Mail order supplies are not covered.

Prescription Drug Exclusions and Limitations

Prescription Drug Exclusions

The following services and supplies are not covered by the HMO Prescription Drug Plan, and a **medical exception is not available for coverage:**

- Any drug that does not, by federal or state law, require a prescription order (such as an over-the-counter drug), even when a prescription is written.
- Any drug that is not medically necessary.
- Charges for the administration or injection of a prescription drug or insulin.
- Cosmetics and any drugs used for cosmetic purposes or to promote hair growth, including (but not limited to) health and beauty aids.
- Any prescription for which the actual charge to you is less than the copayment.
- Any prescription for which no charge is made to you.
- Insulin pumps or tubing for insulin pumps.

- Medication which is to be taken by you or administered to you, in whole or part, while you are a patient in a licensed hospital or similar facility.
- Take-home prescriptions dispensed from a hospital pharmacy upon discharge from the hospital, unless the hospital pharmacy is a participating retail pharmacy.
- Any medication that is consumed or administered at the place where it is dispensed.
- Immunization or immunological agents, including:
 - Biological sera.
 - Blood, blood plasma or other blood products administered on an outpatient basis.
 - Allergy sera and testing materials.
- Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician’s original order.
- Drugs labeled “Caution – Limited by Federal Law to Investigational Use” and experimental drugs.
- Drugs prescribed for uses other than the uses approved by the FDA under the Food, Drug and Cosmetic Law and regulations.
- Medical supplies, devices and equipment, and non-medical supplies and substances, regardless of their intended use.
- Prescription drugs purchased prior to the effective date, or after the termination date, of coverage under this Plan.
- Replacement of lost or stolen prescriptions.
- Performance, athletic performance, or lifestyle-enhancement drugs and supplies.
- Smoking-cessation aids or drugs.
- Test agents and devices, except diabetic test strips.
- Needles and syringes, except diabetic needles and syringes.

Prescription Drug Limitations

The following limitations apply to the prescription drug coverage:

- A participating retail or mail order pharmacy may refuse to fill a prescription order or refill when, in the professional judgment of the pharmacist, the prescription should not be filled.
- Prescriptions may be filled only at a participating retail or mail order pharmacy, except in the event of emergency or urgent care. Plan participants will not be reimbursed for out-of-pocket prescription purchases from a non-participating pharmacy in non-emergency, non-urgent care situations.
- Plan participants must present their ID cards at the time each prescription is filled to verify coverage. If you do not present your ID card, your purchase may not be covered by the Plan, except in emergency and urgent care situations, and you may be required to pay the entire cost of the prescription drug.

Plan Exclusions and Limitations

Exclusions

The Plan does not cover the following services and supplies:

- Acupuncture and acupuncture therapy, except when performed by a participating physician as a form of anesthesia in connection with covered surgery.
- Ambulance services, when used as routine transportation to receive inpatient or outpatient services.
- Any service in connection with, or required by, a procedure or benefit not covered by the Plan.
- Any services or supplies that are not medically necessary, as determined by CIGNA.
- Biofeedback, except as specifically approved by CIGNA.
- Breast augmentation and otoplasties, including treatment of gynecomastia.
- Charges for canceled office visits or missed appointments.
- Care for conditions that, by state or local law, must be treated in a public facility, including mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem. However, the Plan covers the following:
 - Reconstructive surgery to correct the results of an injury.
 - Surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function.
 - Surgery to reconstruct a breast after a mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure.
- Court-ordered services and services required by court order as a condition of parole or probation, unless medically necessary and provided by participating providers upon referral from your Primary Care Physician.
- Custodial care and rest cures.
- Dental care and treatment (other than accidental dental injuries, see page 8).
- Educational services, special education, remedial education or job training. Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and developmental delays are not covered by the Plan.
- Expenses that are the legal responsibility of Medicare or a third party payor.
- Experimental and investigational services and procedures; ineffective surgical, medical, psychiatric, or dental treatments or procedures; research studies; or other experimental or investigational health care procedures or pharmacological regimes, as determined by CIGNA, unless approved by CIGNA in advance.

This exclusion will not apply to drugs:

- That have been granted investigational new drug (IND) or Group c/treatment IND status,
- That are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute, or
- That CIGNA has determined, based upon scientific evidence, demonstrate effectiveness or show promise of being effective for the disease.

Refer to the “Glossary” for a definition of “experimental or investigational.”

- False teeth
- Hair analysis
- Health services, including those related to pregnancy, that are provided before your coverage is effective or after your coverage has been terminated.
- Hearing aids (except as described on page 8), eyeglasses, or contact lenses or the fitting thereof.
- Household equipment, including (but not limited to) the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, is not covered. Improvements to your home or place of work, including (but not limited to) ramps, elevators, handrails, stair glides and swimming pools, are not covered.
- Hypnotherapy, except when approved in advance by CIGNA.
- Immunizations related to travel or work.
- Implantable drugs
- Maintenance Care
- Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision.)
- Outpatient supplies, including (but not limited to) outpatient medical consumable or disposable supplies purchased over the counter such as syringes, incontinence pads, elastic stockings and reagent strips,
- Personal comfort or convenience items, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other similar items and services.
- Private duty or special nursing care while confined in a hospital.
- Radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Recreational and educational, including any related diagnostic testing.
- Religious, marital and sex counseling, including related services and treatment.
- Routine hand and foot care services, including routine reduction of nails, calluses and corns.
- Services or supplies covered by any automobile insurance policy, up to the policy’s amount of coverage limitation.

- Services required by a third party, including (but not limited to) physical examinations, diagnostic services and immunizations in connection with:
 - Obtaining or continuing employment,
 - Obtaining or maintaining any license issued by a municipality, state or federal government,
 - Securing insurance coverage,
 - Travel, and
 - School admissions or attendance, including examinations required to participate in athletics, unless the service is considered to be part of an appropriate schedule of wellness services.

This exclusion does not apply to employer-mandated physical examinations that are prerequisite to participation in a physical fitness test that is required as a condition of continuing employment.

- Services you are not legally obligated to pay for in the absence of this coverage.
- Special education, including lessons in sign language to instruct a Plan participant whose ability to speak has been lost or impaired to function without that ability.
- Special medical reports, including those not directly related to the medical treatment of a Plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation.
- Specific injectable drugs, including:
 - Experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the FDA and the National Institutes of Health,
 - Injectable drugs not considered medically necessary or used for cosmetic, performance, or enhancement purposes, or not specifically covered under this plan,
 - Drugs related to treatments not covered by the Plan, and
 - Drugs related to performance-enhancing steroids.
- Specific non-standard allergy services and supplies, including (but not limited to):
 - Skin titration (rinkel method),
 - Cytotoxicity testing (Bryan’s Test),
 - Treatment of non-specific candida sensitivity, and
 - Urine autoinjections.
- Speech therapy for treatment of delays in speech development *except* when deemed medically necessary for a member with autism or PDD.
- Supportive Care
- Surgical operations, procedures or treatment of obesity, except when approved in advance by CIGNA.
- Therapy or rehabilitation, including (but not limited to):
 - Primal therapy
 - Chelation therapy, except for heavy metal poisoning

- Rolfing
- Psychodrama
- Megavitamin therapy
- Purging
- Bioenergetic therapy
- Vision perception training
- Carbon dioxide therapy
- Thermograms and thermography
- Transsexual surgery, sex change or transformation. The Plan does not cover any procedure, treatment or related service (including, but not limited to, psychological counseling and hormonal therapy) designed to alter a Plan participant's physical characteristics from their biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.
- Treatment in a federal, state or governmental facility, including care and treatment provided in a nonparticipating hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
- Treatment, including therapy, supplies and counseling, for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Treatment of diseases, injuries or disabilities related to military service for which you are entitled to receive treatment at government facilities that are reasonably available to you.
- Treatment of injuries sustained while committing a felony.
- Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to mental health services or medical treatment of the retarded individual.
- Treatment of occupational injuries and occupational diseases, including injuries that arise out of (or in the course of) any work for pay or profit, or in any way result from a disease or injury which does. If you are covered under a Workers' Compensation law or similar law, and submit proof that you are not covered for a particular disease or injury under such law, that disease or injury will be considered "non-occupational," regardless of cause.
- Treatment of temporomandibular joint (TMJ) syndrome including (but not limited to):
 - Treatment performed by placing a prosthesis directly on the teeth,
 - Surgical and non-surgical medical and dental services, and
 - Diagnostic or therapeutic services related to TMJ.
- Weight reduction programs and dietary supplements.

Limitations

In the event there are two or more alternative medical services that, in the sole judgment of CIGNA, are equivalent in quality of care, the Plan reserves the right to cover only the least costly service, as determined by CIGNA, provided that CIGNA approves coverage for the service or treatment in advance.

In Case of Medical Emergency

Guidelines

If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. CIGNA has adopted the following definition of an emergency medical condition from the Balanced Budget Act (BBA) of 1997:

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- *Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;*
- *Serious impairment to bodily function; or*
- *Serious dysfunction of any bodily organ or part.*

All procedures performed during the evaluation (triage) and treatment of an emergency medical condition shall be covered by CIGNA HealthCare.

Some examples of emergencies are:

- Heart attack or suspected heart attack.
- Suspected overdose of medication.
- Poisoning.
- Severe burns.
- Severe shortness of breath.
- High fever (especially in infants).
- Uncontrolled or severe bleeding.
- Loss of consciousness.

Whether you are in or out of CIGNA's service area, we ask that you follow the guidelines listed below when you believe you may need emergency care.

1. Call your Primary Care Physician first, if possible. Your Primary Care Physician is required to provide urgent care and emergency coverage 24 hours a day, including weekends and holidays. However, if a delay would be detrimental to your health, seek the nearest emergency facility, or dial 911 or your local emergency response service.
2. After assessing and stabilizing your condition, the emergency facility should contact your Primary Care Physician so they can assist the treating physician by supplying information about your medical history.
3. If you are admitted to an inpatient facility, notify your Primary Care Physician as soon as reasonably possible. The emergency room copayment will be waived if you are admitted to the hospital.
4. All follow-up care must be coordinated by your Primary Care Physician.
5. If you go to an emergency facility for treatment that CIGNA determines is non-emergency in nature, you will be responsible for the bill. The Plan does not cover non-emergency use of the emergency room.

Follow-Up Care after Emergencies

All follow-up care should be coordinated by your Primary Care Physician. You must have a referral from your Primary Care Physician **and** approval from CIGNA to receive follow-up care from a nonparticipating provider. Whether you were treated inside or outside your CIGNA service area, you must obtain a referral before any follow-up care can be covered. Suture removal, cast removal, X-rays, and clinic and emergency room revisits are some examples of follow-up care.

Urgent Care

Treatment that you obtain outside of your service area for an urgent medical condition is covered if:

- The service is a covered benefit;
- You could not reasonably have anticipated the need for the care prior to leaving the network service area; and
- A delay in receiving care until you could return and obtain care from a participating network provider would have caused serious deterioration in your health.

What to Do Outside Your CIGNA Service Area

Plan participants who are traveling outside the service area, or students who are away at school, are covered for emergency care and treatment of urgent medical conditions. Urgent care may be obtained from a private practice physician, a walk-in clinic, or an urgent care center. An urgent medical condition that occurs outside your CIGNA service area can be treated in any of the settings described above. In the event you need Urgent Care while outside the service area, you should, whenever possible, contact your PCP or the CIGNA HealthCare 24-Hour Health Information LineSM for direction and authorization prior to receiving services.

If, after reviewing information submitted to CIGNA by the provider(s) who supplied your care, the nature of the urgent or emergency problem does not clearly qualify for coverage, it may be necessary to provide additional information.

Lastly, CIGNA does offer Guest Privileges. This program enables you to maintain your CIGNA HealthCare coverage when you or your covered family members are temporarily away from your usual services area for at least 60 days. Call Member Services to find out if you qualify.

Specialty Programs

Case Management

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility.

Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers

are also available to answer questions and provide ongoing support for the family in times of medical crisis. Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your Dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to date treatment programs and medical technology.

While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

You, your dependent, or an attending Physician can request Case Management services by calling the toll-free number shown on your ID card during normal business hours, Monday through Friday. In addition, your employer, a claim office or a utilization review program may refer an individual for Case Management. The Review Organization assesses each case to determine whether Case Management is appropriate. You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary — no penalty or benefit reduction is imposed if you do not wish to participate in Case Management. Following an initial assessment, the Case Manager works with you, your family, and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed. The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home). The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan). Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

CIGNA HealthCare 24-Hour Health Information LineSM

"Sometimes a few words of understanding and compassion are more helpful than medicine."
— CIGNA HealthCare Member

It's 2:00 a.m. Your child has a fever. Or you're traveling, you don't feel well, and you're unsure about what to do. The answers are as close as the nearest phone.

The CIGNA HealthCare 24-Hour Health Information LineSM is always available—day or night—for personal and confidential information on a wide range of health-related topics. You can either speak directly with a registered nurse, or listen to prerecorded information.

How to Call

You'll receive the toll-free 24-Hour Health Information Line number after you enroll in a CIGNA HealthCare medical plan. If you're currently a CIGNA HealthCare member, you can access the phone number by logging in to: myCIGNA.com or by calling the Member Services number on your CIGNA HealthCare ID card.

When you call the 24-Hour Health Information Line, you'll have two options:

1. Speak directly with a registered nurse.

A specially trained team of nurses is on duty around the clock. The nurse will ask you a few questions about your symptoms and situation, then direct you to the type of care that should make you more comfortable.

2. Listen to recorded information in our audio library.

You can listen to tapes on topics ranging from aging and women's health to nutrition and surgery. The tapes are regularly updated to include new treatments and medical data. You can listen to as many tapes as you'd like.

Don't worry, wonder or wait — whenever there's a question about health, just call the number on your CIGNA HealthCare ID card. We'll be here!

CIGNA Well Aware for Better HealthSM

CIGNA Personal Health Team. Free live and online support to improve your health! You decide what services will work for you and when you want them, or CIGNA may contact you. Call 1-800-CIGNA24 for live support from your health advocate or log on to myCIGNA.com for self-service resources. Get the support you need to improve your lifestyle. If tobacco or stress are affecting your health or ability to live a balanced life, it may be time to take the first step toward making some changes. Use our online or telephone coaching programs – or both – for the support you need to improve your lifestyle.

Support for chronic conditions — manage your chronic condition with help from CIGNA Personal Health Team. The Personal Health Team can help you:

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

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

CIGNA HealthCare Healthy Babies[®]

Give your baby-to-be a healthy start. The most precious gift you can give your baby is a healthy start in life. As a mother-to-be, there are steps you can take now to help improve your baby's health. The CIGNA HealthCare Healthy Babies[®] program gives you the information and support

you need to make the best choices for yourself and your growing baby. When you enroll in Healthy Babies you'll get:

- Valuable educational materials you can use as a resource throughout your pregnancy, including:
 - Guidelines for a healthy pregnancy and baby.
 - Information on health issues that can impact pregnant women and their babies, including stress, depression and gum disease.
 - A guide to pregnancy-related topics available through the CIGNA HealthCare 24-Hour Health Information Line.SM
 - A list of informative online and telephone resources.
 - Information on prenatal care from the March of Dimes®—a recognized source of information on pregnancy and babies.
- Round-the-clock access to a toll-free information line staffed by experienced registered nurses.

You may also be eligible for support from a registered nurse case manager if you or your baby has special health care needs.

CIGNA HealthCare also provides members access to special discounts on pregnancy related books through its Healthy Rewards® member discount program.

To enroll, just call the toll-free number on your CIGNA HealthCare ID card, any time during your pregnancy.

The Healthy Babies program is offered in addition to the services covered as part of a CIGNA HealthCare medical benefit plan.

March of Dimes®

At CIGNA HealthCare, we're proactive about helping babies and their mothers be healthy. Working with the March of Dimes, we're making every effort to see that babies get a fighting chance. Every day, babies are born struggling for their lives. And every day, the March of Dimes helps them win. We're proud to be the exclusive national health care sponsor for March of Dimes WalkAmerica®... the walk that saves babies.

CIGNA HealthCare and March of Dimes—Saving babies, together®.

Member Discounts from Healthy Rewards®

CIGNA Healthy Rewards® includes special discounts on programs and services designed to help you enhance your health and wellness. The offers include brand names such as Weight Watchers®, Jenny Craig®, Pearle Vision®, Bally Total Fitness™, Curves®, drugstore™ and more.

No referrals. No claim forms. No catch.

If you have CIGNA coverage, the choice to use Healthy Rewards is entirely yours. The program is separate from your coverage, so the services don't apply to your plan's copays or coinsurance.

No doctor's referral is required – and no claim forms, either. Set the appointments yourself, show your ID card when you pay for services and enjoy the savings.

Discounts are available for the following health and wellness programs:

- Weight Management and Nutrition
- Fitness
- Tobacco Cessation
- Mind/Body
- Vision and Hearing Care
- Vitamins, Health and Wellness Products
- Alternative Medicine
- Healthy Lifestyle Products
- Dental Care

Good health is its own reward. So consider this a well-deserved bonus. For a complete list of Healthy Rewards vendors and programs, visit myCIGNA.com or call 1.800.870.3470.

Quit TodaySM Smoking Cessation Program

Quit TodaySM tobacco cessation program is designed to help you proactively address the challenges in life that affect your health and wellness. The key to successful change in our Tobacco Cessation program is in managing behavior.

You may choose to enroll in online or telephonic sessions. After registration and self-assessment, a trained personal health coach will work with you to identify behavior patterns that cause you to struggle and chart a course for change and improvement. At-home toolkits help you track your progress. Our online program even includes the opportunity to learn and support others on the same path.

Enhanced Online Tools

You have access to a suite of tools that deliver on-demand support. Log on for convenient, easy access to:

- Information about your benefits, health and well-being articles, in-network providers and treatment options.
- Self-assessment tools
- An extensive library of information about various medical and behavioral health topics
- Online Coaching

Online Coaching puts you in touch with a licensed behavioral health professional who can offer one-on-one guidance and support for a variety of critical issues. Online Coaching modules include:

- Personal Quit Plan
- An 8-week self paced program

- Weekly educational emails with key learning themes and tips
- Health Rewards discounts
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Eligibility

Active Employee Eligibility

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

To be eligible for State employee coverage, you must work full-time for the State of New Jersey or be an appointed or elected officer of the State of New Jersey (this includes employees of a State agency or authority and employees of a State college or university). For State employees, "full-time" requires at least 35 hours per week or more if required by contract or resolution.

To be eligible for local employer coverage, you must be a full-time employee or an appointed or elected officer receiving a salary from a local employer (county, municipality, county or municipal authority, board of education, etc.) that participates in the SHBP or SEHBP.

Each participating local employer defines the minimum hours required for full-time by a resolution filed with the Division of Pensions and Benefits, but it can be no less than 25 hours per week or more if required by contract or resolution. Employment must also be for 12 months per year, except for employees whose usual work schedule is 10 months per year (the standard school year).

Enrollment

You are not covered until you enroll in the SHBP or SEHBP. You must fill out a *Health Benefits Program Application* and provide all the information requested. If you do not enroll all eligible members of your family within 60 days of the time you or they first become eligible for coverage, you must wait until the next Open Enrollment period to do so. Open Enrollment periods generally occur once a year usually during the month of October. Information about the dates of the Open Enrollment period and effective dates for coverage is announced by the Division of Pensions and Benefits.

Eligible Dependents

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

Spouse — is a person of the opposite sex to whom you are legally married. A photocopy of the *Marriage Certificate* and additional supporting documentation are required for enrollment.

Civil Union Partner — 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 additional supporting documentation are required for enrollment. The cost of a civil union partner's coverage may be subject to federal tax (see your employer or [Fact Sheet #75, Civil Unions](#), for details).

Domestic Partner — 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 additional supporting documentation are required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer or [Fact Sheet #71, Benefits under the Domestic Partnership Act](#), for details).

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

For a stepchild provide a photocopy of the child's birth certificate showing the spouse/partner's name as a parent **and** a photocopy of marriage/partnership certificate showing the names of the employee/retiree and spouse/partner.

Foster children and children in a guardian-ward relationship under age 26 are also eligible. A photocopy of the child's birth certificate **and** additional supporting legal documentation are

required with enrollment forms for these cases. Documents must attest to the legal guardianship by the covered employee (see page 62).

Coverage for an enrolled child ends on December 31 of the year in which he or she turns age 26 (see the “COBRA” section on page 37, “Dependent Children with Disabilities” and “Over Age Children Until Age 31” below for continuation of coverage provisions).

Note: Coverage until age 26 is only available if the child is not eligible to enroll in other employer-based coverage (aside from coverage through the parent).

Dependent Children with Disabilities — If a child is not capable of self-support when he or she reaches age 26 due to mental illness, mental retardation, or a physical disability, he or she may be eligible for a continuance of coverage.

To request continued coverage, contact the Office of Client Services at (609) 292-7524 or write to the Division of Pensions and Benefits, Health Benefits Bureau, 50 West State Street, P. O. Box 299, Trenton, New Jersey 08625 for a *Continuance for Dependent with Disabilities* form. The form and proof of the child's condition must be given to the Division no later than 31 days after the date coverage would normally end.

Since coverage for children ends on December 31 of the year they turn 26, you have until January 31 to file the *Continuance for Dependent with Disabilities* form. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP or SEHBP, and (2) the child continues to be disabled, and (3) the child is unmarried, and (4) the child remains dependent on you for support and maintenance and lives with you. You will be contacted periodically to verify that the child remains eligible for continued coverage.

See [Fact Sheet #51](#), *Continuing Health Benefits Coverage for Over Age Children with Disabilities*, for more information.

Over Age Children Until Age 31 — Certain children over age 26 may be eligible for coverage until age 31 under the provisions of Chapter 375, P.L. 2005, as amended by Chapter 38, P.L. 2008. This includes a child by blood or law who is under the age of 31; is unmarried; has no dependent(s) of his or her own; is a resident of New Jersey or is a full-time student at an accredited public or private institution of higher education; and is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare.

Under Chapter 375, an over age child does not have any choice in the selection of benefits but is enrolled for coverage in exactly the same plan or plans (medical and/or prescription drug) that the covered parent has selected. The covered parent or child is responsible for the entire cost of coverage. There is no provision for dental or vision benefits.

Coverage for an enrolled over age child will end when the child no longer meets any one of the eligibility requirements or if the required payment is not received. Coverage will also end when the covered parent's coverage ends. Coverage ends on the first of the month following the event that makes the dependent ineligible or up until the paid through date in the case of non-payment.

See [Fact Sheet #74](#), *Health Benefits Coverage of Children until Age 31 under Chapter 375*, for details.

Supporting Documentation Required for Enrollment of Dependents

The SHBP and SEHBP are required to ensure that only eligible employees and retirees, and their dependents, are receiving health care coverage under the program. Retirees who enroll dependents for coverage (spouses, civil union partners, domestic partners, children, disabled dependents, and over age children continuing coverage) must submit supporting documentation in addition to the enrollment application. See page 61 for more information about the documentation a member must provide when enrolling a new dependent for coverage.

Audit of Dependent Coverage

Periodically, the Division of Pensions and Benefits performs an audit using a random sample of members to determine if enrolled dependents are eligible under plan provisions. Proof of dependency such as a marriage, civil union, or birth certificates, or tax returns are required. Coverage for ineligible dependents will be terminated. Failure to respond to the audit will result in the termination of ALL coverage and may include financial restitution for claims paid. Members who are found to have intentionally enrolled an ineligible person for coverage will be prosecuted to the fullest extent of the law.

Multiple Coverage under the SHBP/SEHBP is Prohibited

State statute specifically prohibits two members who are each enrolled in SHBP/SEHBP plans from covering each other. Therefore, an eligible individual may only enroll in the SHBP/SEHBP as an employee or retiree, or be covered as a dependent.

Eligible children may only be covered by one participating subscriber.

For example, a husband and wife both have coverage based on their employment and have children eligible for coverage. One may choose Family coverage, making the spouse and children the dependents and ineligible for any other SHBP/SEHBP coverage; or one may choose Single coverage and the spouse may choose Parent and Child(ren) coverage.

Medicare Coverage While Employed

In general, it is not necessary for a Medicare-eligible employee, spouse, civil union partner, eligible same-sex domestic partner, or dependent child(ren) to be covered by Medicare while the employee remains actively at work. **However, if you or your dependents become eligible for Medicare due to End Stage Renal Disease (ESRD) you and/or your dependents must enroll in Medicare Parts A and B even though you are actively at work.** For more information, see “Medicare Coverage” in the Retiree Eligibility section.

Retiree Eligibility

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

- Full-time State employees, employees of State colleges/universities, autonomous State agencies and commissions, or local employees who were covered by, or eligible for, the SHBP at the time of retirement.

- Part-time State employees and part-time faculty at institutions of higher education that participate in the SHBP if enrolled in the SHBP at the time of retirement.
- Participants in the Alternate Benefit Program (ABP) eligible for the SHBP who retire with at least 25 years of credited ABP service or those who are on a long-term disability.
- Certain local policemen or firemen with 25 years or more of service credit in the pension fund or retiring on a disability retirement if the employer does not provide any payment or compensation toward the cost of the retiree's health benefits. A qualified retiree may enroll at the time of retirement or when he or she becomes eligible for Medicare. See [Fact Sheet #47](#), *Retired Health Benefits Coverage under Chapter 330*, for more information.
- Surviving spouses, civil union partners, eligible same-sex domestic partners, and children of Police and Firemen's Retirement System (PFRS) members or State Police Retirement System (SPRS) members killed in the line of duty.

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

- Full-time members of the Teachers' Pension and Annuity Fund (TPAF) and school board or county college employees enrolled in the Public Employees' Retirement System (PERS) who retire with less than 25 years of service credit from an employer that participates in the SEHBP.
- Full-time members of the TPAF and school board or county college employees enrolled in the PERS who retire with 25 years or more of service credit in one or more State or locally-administered retirement systems or who retire on a disability retirement, even if their employer did not cover its employees under the SEHBP. This includes those who elect to defer retirement with 25 or more years of service credit in one or more State or locally-administered retirement systems (see "Aggregate of Pension Membership Service Credit" on page 33).
- Full-time members of the TPAF and PERS who retire from a board of education, vocational/technical school, or special services commission; maintain participation in the health benefits plan of their former employer; and are eligible for and enrolled in Medicare Parts A and B.
- Participants in the Alternate Benefit Program (ABP) eligible for the SEHBP who retire with at least 25 years of credited ABP service or those who are on a long-term disability.
- Part-time faculty at institutions of higher education that participate in the SEHBP if enrolled in the SEHBP at the time of retirement.

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

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

This means that if you allow your active coverage to lapse (i.e. because of a leave of absence, reduction in hours, or termination of employment) prior to your retirement or you defer your retirement for any length of time after leaving employment, you will lose your eligibility for Retired Group health coverage. (This does not include full-time TPAF retirees and PERS board of education or county college retirees with 25 or more years of service).

Note: If you continue group coverage through COBRA (see page 37 for an explanation of COBRA) — or as a dependent under other group coverage through a public or private employer — until your retirement becomes effective, you will be eligible for retired coverage under the SHBP or SEHBP.

Otherwise qualified employees whose coverage is terminated prior to retirement **but who are later approved for a disability retirement** will be eligible for Retired Group coverage beginning on the employee's retirement date. If the approval of the disability retirement is delayed, coverage shall not be retroactive for more than one year.

Aggregate of Pension Membership Service Credit

Upon retirement, a full-time State employee, board of education, or county college employee who has 25 years or more of service credit, is eligible for State-paid health benefits under the SHBP or SEHBP.

A full-time employee of a local government who has 25 years or more of service credit whose employer is enrolled in the SHBP **and** has chosen to provide post-retirement medical coverage to its retirees is eligible for employer-paid health benefits under the SHBP.

A retiree eligible for the SHBP or SEHBP may receive this benefit if the 25 years of service credit is from one or more State or locally-administered retirement systems and the time credited is nonconcurrent.

For PERS or TPAF members, Out-of-State Service, U.S. Government Service, or service with a bi-state or multi-state agency, requested for purchase *after* November 1, 2008, cannot be used to qualify for any State-paid or employer-paid health benefits in retirement.

Eligible Dependents of Retirees

Dependent eligibility rules for Retired Group coverage are the same as for Active Group coverage (see page 29) except for Chapter 334 domestic partners (described below) and the Medicare requirements (below).

Chapter 334, P.L. 2005, provides that retirees from local entities (municipalities, counties, boards of education, and county colleges) whose employers do not participate in the in SHBP or SEHBP, but who become eligible for SHBP or SEHBP coverage at retirement (see page 31), may also enroll a registered same-sex domestic partner as a covered dependent provided that the former employer's plan includes domestic partner coverage for employees.

Multiple Coverage under the SHBP/SEHBP is Prohibited

State statute specifically prohibits two members who are each enrolled in SHBP/SEHBP plans from covering each other. Therefore, an eligible individual may only enroll in the SHBP/SEHBP as an employee or retiree, or be covered as a dependent.

Eligible children may only be covered by one participating subscriber.

For example, a husband and wife both have coverage based on their employment and have children eligible for coverage. One may choose Family coverage, making the spouse and children the dependents and ineligible for any other SHBP/SEHBP coverage; or one may choose Single coverage and the spouse may choose Parent and Child(ren) coverage.

Enrolling in Retired Group Coverage

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

If you do not submit a *Retired Coverage Enrollment Application* at the time of retirement, you will not generally be permitted to enroll for coverage at a later date. See [Fact Sheet #11, Enrolling for Health Benefits Coverage When You Retire](#), for more information.

If you believe you are eligible for Retired Group coverage and do not receive an offering letter by the date of your retirement, please contact the Division of Pensions and Benefits, Office of Client Services at (609) 292-7524 or send an e-mail to: pensions.nj@treas.state.nj.us.

Additional restrictions and/or requirements may apply when enrolling in Retired Group coverage. Be sure to carefully read the “Retiree Enrollment” section of the *Summary Program Description* which is available on the Division of Pensions and Benefits Web site at: www.state.nj.us/treasury/pensions/health-benefits.shtml

Medicare Coverage

IMPORTANT: A Retired Group member and/or dependent spouse, civil union partner, eligible same-sex domestic partner, or child who is eligible for Medicare coverage by reason of age or disability must be enrolled in both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to enroll or remain in SHBP or SEHBP Retired Group coverage.

Medicare Parts A and B

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

IMPORTANT: If a provider does not participate with Medicare, no benefits are payable under the SHBP or SEHBP for the provider’s services, the charges would not be considered under the medical plan, and the member will be responsible for the charges.

Medicare Part D

The prescription drug benefits provided through the SHBP and SEHBP Retired Group medical plans are equal to or better than the benefits provided by the standard Medicare Part D plan. Therefore, most Medicare eligible retirees and/or their Medicare eligible dependents need not enroll in Medicare Part D prescription drug coverage. While some SHBP or SEHBP members who qualify for low income subsidy programs may find it beneficial to enroll in Medicare Part D, once you and/or a dependent enroll in a Medicare Part D plan, the person enrolled in Medicare Part D will lose their SHBP or SEHBP prescription drug coverage. In addition, the SHBP and SEHBP will not cover the costs of any drugs that are not covered by the Medicare Part D plan.

Medicare Eligibility

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

- **Medicare Eligibility by Reason of Age**

This applies to a member who is the retiree, a covered spouse, civil union partner, or eligible same-sex domestic partner and is at least 65 years of age. A member is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if he or she is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his/her 65th birthday. **The retired group health plan is the secondary plan.**

- **Medicare Eligibility by Reason of Disability**

This applies to a member who is under age 65. A member is considered to be eligible for Medicare by reason of disability if they have been receiving Social Security Disability benefits for 24 months. **The retired group health plan is the secondary plan.**

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

A member usually becomes eligible for Medicare at age 65 or upon receiving Social Security Disability benefits for two years. A member who is not eligible for Medicare because of age or disability may qualify because of treatment for End Stage Renal Disease (ESRD).

When a person is eligible for Medicare due to ESRD, **Medicare is the secondary payer when:**

- The individual has group health coverage of their own or through a family member (including a spouse, civil union partner, or domestic partner).
- The group health coverage is from either a current employer or a former employer. The employer may be of any size (not limited to employers with more than 20 employees).

The rules described above, known as the Medicare Secondary Payer (MSP) rules, are federal regulations that determine whether Medicare pays first or second to the group health plan. These rules have changed over time. As of January 1, 2000, where the member becomes eligible for Medicare solely on the basis of ESRD, the Medicare eligibility can be segmented into three parts:

- (1) An initial three-month waiting period;
- (2) A "coordination of benefits" period; and
- (3) A period where Medicare is primary.

Three-month Waiting Period

Once a person has begun a regular course of renal dialysis for treatment of ESRD, there is a three-month waiting period before the individual becomes entitled to Medicare Parts A and B benefits. During the initial three-month period, **the group health plan is primary.**

Coordination of Benefits Period

During the "coordination of benefits" period, **Medicare is secondary to the group health plan coverage.** Claims are processed first under the health plan. Medicare considers the claims as a secondary carrier. For members who became eligible for Medicare due solely to ESRD after 1996, the coordination of benefits period is 30 months.

When Medicare is Primary

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

• Dual Medicare Eligibility

When the member is eligible for Medicare because of age or disability and then becomes eligible for Medicare because of ESRD:

- If the health plan is primary because the member has active employment status, then **the group health plan continues to be primary** to 30 months from the date of dual Medicare entitlement.
- If the health plan is secondary because the member is not actively employed, then **the health plan continues to be the secondary payer.** There is no 30-month coordination period.

How to File a Claim If You Are Eligible for Medicare

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

New Jersey Physicians or Providers:

- You should provide the physician or provider with your identification number. This number is indicated on the *Medicare Request for Payment* (claim form) under "Other Health Insurance."
- The physician or provider will then submit the *Medicare Request for Payment* to the Medicare Part B carrier.
- After Medicare has taken action; you will receive an *Explanation of Benefits* statement from Medicare.
- If the remarks section of the *Explanation of Benefits* contains the following statement; you need not take any action: "This information has been forwarded to CIGNA for their consideration in processing supplementary coverage benefits."
- If the statement shown above does not appear on the *Explanation of Benefits*, you should indicate your Social Security number and the name and address of the physician or provider in the remarks section of the *Explanation of Benefits* with a completed claim form and send it to the address on the claim form.

Out-Of-State Physicians or Providers:

- The *Medicare Request for Payment* form should be submitted to the Medicare Part B carrier in the area where services were performed. Call your local Social Security office for information.
- When you receive the *Explanation of Benefits*, indicate your identification number and the name and address of the physician or provider in the *Explanation of Benefits* with a completed claim form to the address on the claim form.

COBRA Coverage

Continuing Coverage When It Would Normally End

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federally regulated law that gives employees and their eligible dependents the opportunity to remain in their employer's group coverage when they would otherwise lose coverage because of certain qualifying events. COBRA coverage is available for limited time periods, and the member must pay the full cost of the coverage plus an administrative fee.

Leave taken under the federal and/or State Family Leave Act is not subtracted from your COBRA eligibility period.

Under COBRA, you may elect to enroll in any or all of the coverages you had as an active employee or dependent (health, prescription, dental, and vision). You may also change your health or dental plan when enrolling in COBRA. You may elect to cover the same dependents that you covered while an active employee, or delete dependents from coverage — however, you *cannot* add dependents who were not covered while an employee except during the annual Open Enrollment period (see below) or unless a "qualifying event" (marriage, birth or adoption of a child, etc.) occurs within 60 days of the COBRA event.

Open Enrollment — COBRA enrollees have the same rights to coverage at Open Enrollment as are available to active employees. This means that you or a dependent who elected to enroll under COBRA are able to enroll, if eligible, in any medical, dental, or prescription drug coverage during the Annual Open Enrollment Period regardless of whether you elected to enroll for the coverage when you went into COBRA. This affords a COBRA enrollee the same opportunity to enroll for benefits during the Annual Open Enrollment Period as an active employee. However, any time of non-participation in the benefit is counted toward your maximum COBRA coverage period. If the State Health Benefits Commission or School Employees' Health Benefits Commission make changes to any benefit plan available to active employees and/or retirees, those changes apply equally to COBRA participants.

COBRA Events

Continuation of group coverage under COBRA is available if you or any of your covered dependents would otherwise lose coverage as a result of any of the following events:

- Termination of employment (except for gross misconduct).
- Death of the member.
- Reduction in work hours.

- Leave of absence.
- Divorce, legal separation, dissolution of a civil union or domestic partnership (makes spouse, civil union partner, or same-sex domestic partner ineligible for further dependent coverage).
- Loss of a dependent child's eligibility through the attainment of age 26.
- The employee elects Medicare as primary coverage. (Federal law requires active employees to terminate their employer's health coverage if they want Medicare as their primary coverage.)

The occurrence of the COBRA event must be the reason for the loss of coverage for you or your dependent to be able to take advantage of the provisions of the law. If there is no coverage in effect at the time of the event, there can be no continuation of coverage under COBRA.

Cost of COBRA Coverage

If you choose to purchase COBRA benefits, you pay 100 percent of the cost of the coverage plus a two percent charge for administrative costs.

Duration of COBRA Coverage

COBRA coverage may be purchased for up to 18 months if you or your dependents become eligible because of termination of employment, a reduction in hours, or a leave of absence.

Coverage may be extended up to 11 additional months, for a total of 29 months, if you have a Social Security Administration approved disability (under Title II or XVI of the Social Security Act) for a condition that existed when you enrolled in COBRA or began within the first 60 days of COBRA coverage. Coverage will cease either at the end of your COBRA eligibility or when you obtain Medicare coverage, whichever comes first.

COBRA coverage may be purchased by a dependent for up to 36 months if he or she becomes eligible because of your death, divorce, dissolution of a same-sex domestic partnership, or a child attaining age 26, or because you elected Medicare as your primary coverage.

If a second qualifying event occurs during the 18-month period following the date of any employee's termination or reduction in hours, the beneficiary of that second qualifying event will be entitled to a total of 36 months of continued coverage. The period will be measured from the date of the loss of coverage caused by the first qualifying event.

Employer Responsibilities Under COBRA

The COBRA law requires employers to:

- Notify you and your dependents of the COBRA provisions within 90 days of when you and your dependents are first enrolled;
- Notify you, your spouse, civil union partner, or eligible same-sex domestic partner, and your children of the right to purchase continued coverage within 14 days of receiving notice that there has been a COBRA qualifying event that causes a loss of coverage;
- Send the *COBRA Notification Letter* and a *COBRA Application* within 14 days of receiving notice that a COBRA qualifying event has occurred;

- Notify the Health Benefits Bureau of the Division of Pensions and Benefits within 30 days of the loss of an employee's coverage; and
- Maintain records documenting their compliance with the COBRA law.

Employee Responsibilities Under COBRA

The law requires that you and your dependents:

- Notify your employer (if you are retired, you must notify the Health Benefits Bureau of the Division of Pensions and Benefits) that a divorce, legal separation, dissolution of a civil union or a same-sex domestic partnership, or that your child has reached age 26. Notification must be given within 60 days of the date the event occurred;
- File a *COBRA Application* within 60 days of the loss of coverage or the date of the *COBRA Notice* provided by your employer, whichever is later;
- Pay the required monthly premiums in a timely manner; and
- Pay premiums, when billed, retroactive to the date of group coverage termination.

Failure to Elect COBRA Coverage

In considering whether to elect continuation of coverage under COBRA, an eligible employee, retiree, or dependent (also known as a “qualified beneficiary” under COBRA law) should take into account that a failure to continue group health coverage will affect future rights under federal law.

- First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. The election of continuation of coverage under COBRA may help you to bridge such a gap. (If, after enrolling in COBRA you obtain new coverage which has a pre-existing condition clause, you may continue your COBRA enrollment to cover the condition excluded by the pre-existing condition clause.)
- Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition exclusions if you do not continue coverage under COBRA for the maximum time available to you.
- Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse/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 if you get the continuation of coverage under COBRA for the maximum time available to you.

Termination of COBRA Coverage

Your COBRA coverage will end when any of the following situations occur:

- Your eligibility period expires;
- You fail to pay your premiums in a timely manner;

- After the COBRA event, you become covered under another group insurance program (unless a preexisting clause applies);
- You voluntarily cancel your coverage;
- Your employer drops out of the SHBP or SEHBP;
- You become eligible for Medicare after you elect COBRA coverage. (This affects health insurance only, not dental, prescription, or vision coverage.)

Termination for Cause

Your coverage and the coverage of your dependents under this Plan may be terminated for cause. “For cause” is defined as:

- **Untenable relationship:** After reasonable efforts, CIGNA and/or the Plan’s participating providers are unable to establish and maintain a satisfactory provider-patient relationship with the member, or the member repeatedly acts in a manner which is verbally or physically abusive.
- **Failure to make copayments:** The member fails to make required copayments or any other payment which he or she is required to pay.
- **Misuse of identification card:** The member permits a person who is not a member of the Plan to use his or her CIGNA identification card.
- **Furnishing incorrect or incomplete information:** The member willfully furnishes incorrect or incomplete information in a statement made for the purpose of enrolling in or obtaining benefits from the Plan.
- **Non-compliance with your physician’s plan of treatment:** You have the right to refuse any drugs, treatment or other procedure offered to you by a participating provider, and to be informed by your physician of the medical consequences of your refusal of any drugs, treatment or procedure. CIGNA and your Primary Care Physician will make every effort to arrange a professionally acceptable alternative treatment. However, if you still refuse the recommended plan of treatment, the Plan will not be responsible for the costs of further treatment for that condition, and you will be so notified. You may use the grievance and appeal process to have your case reviewed (see page 45).
- **Misconduct:** The member abuses the system, including, but not limited to, theft, fraud, damage to the property of a participating provider or forgery of drug prescriptions.

No benefits, other than for emergency care, will be provided to you and your family members as of 31 days after the date notice of termination is given to you by the State Health Benefits Commission or School Employees’ Health Benefits Commission. Any termination for cause is subject to review in accordance with the Plan’s appeal process. If an appeal to CIGNA is denied, you may appeal to the State Health Benefits Commission or School Employees’ Health Benefits Commission. If the Commission governing your coverage upholds the termination, you must change your coverage by completing a *Health Benefits Program Application* to enroll in another health plan. Benefits under this Plan end when your application is received and processed by the Division of Pensions and Benefits, Health Benefits Bureau. If the Commission overrules the decision to terminate, full coverage will be restored retroactively.

Health Care Fraud

Health care fraud is an intentional deception or misrepresentation that results in an unauthorized benefit to a member or to some other person. Any individual who willfully and knowingly engages in an activity intended to defraud the SHBP or SEHBP will face disciplinary action that could include termination of employment and may result in prosecution. Any member who receives monies fraudulently from a health plan will be required to fully reimburse the plan.

Coordination of Benefits

If you have coverage under other group plans, the benefits from the other plans will be taken into account if you have a claim. This may mean a reduction in benefits under the Plan.

Benefits available through other group plans and/or no-fault automobile coverage will be coordinated with the Plan. “Other group plans” include any other plan of dental or medical coverage provided by:

- Group insurance or any other arrangement of group coverage for individuals, whether or not the plan is insured; and
- “No-fault” and traditional “fault” auto insurance, including medical payments coverage provided on other than a group basis, to the extent allowed by law.

To find out if benefits under the Plan will be reduced, CIGNA must first determine which plan pays benefits first. The determination of which plan pays first is made as follows:

- The plan without a coordination of benefits (COB) provision determines its benefits before the plan that has such a provision.
- The plan that covers a person other than as a dependent determines its benefits before the plan that covers the person as a dependent.
- If the person is eligible for Medicare and is not actively working, the Medicare Secondary Payer rules will apply. Under the Medicare Secondary Payer rules, the order of benefits will be determined as follows:
 - The plan that covers the person as a dependent of a working spouse/civil union or partner will pay first;
 - Medicare will pay second; and
 - The plan that covers the person as a retired employee will pay third.
- Except for children of divorced or separated parents, the plan of the parent whose birthday occurs earlier in the calendar year pays first. When both parents’ birthdays occur on the same day, the plan that has covered the parent the longest pays first. If the other plan doesn’t have the parent birthday rule, the other plan’s COB rule applies.
- When the parents of a dependent child are divorced or separated:
 - If there is a court decree which states that the parents will share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the parent birthday rule, described above, applies.

- If a court decree gives financial responsibility for the child’s medical, dental or other health care expenses to one of the parents, the plan covering the child as that parent’s dependent determines its benefits before any other plan that covers the child as a dependent.
- If there is no such court decree, the order of benefits will be determined as follows:
 - The plan of the natural parent with whom the child resides,
 - The plan of the stepparent with whom the child resides,
 - The plan of the natural parent with whom the child does not reside, or
 - The plan of the stepparent with whom the child does not reside.
- If an individual has coverage as an active employee or dependent of such employee, and also as a retired or laid-off employee, the plan that covers the individual as an active employee or dependent of such employee is primary.
- The benefits of a plan which covers a person under a right of continuation under federal or state laws will be determined after the benefits of any other plan which does not cover the person under a right of continuation.
- If the rules listed above do not establish an order of payment, the plan that has covered the person for the longest time will pay benefits first.

In determining the amount to be paid when this plan is secondary on a claim, the secondary plan will calculate the benefits that it would pay on the claim in the absence of other health insurance coverage and apply that amount to any allowable expense under this plan that was unpaid by the primary plan. The amount will be reduced so that when combined with the amount paid by the plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense. In addition, a secondary plan will credit to its plan deductible any amounts that would have been credited in the absence of other coverage.

Under the COB provision of this Plan, the amount normally reimbursed for covered benefits or expenses under this Plan is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under this Plan for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. Such reduced amounts will be charged against any applicable benefit limit of this coverage.

If your other plan(s) provides benefits in the form of services rather than cash payments, the cash value of the services will be used in the calculation.

If You Receive a Bill

Because you are a participant in a CIGNA HMO, you do not need to submit a claim for most of your covered healthcare expenses. However, if you receive a bill for covered services, the bill must be submitted promptly to CIGNA for payment. Send the itemized bill for payment with your identification number clearly marked to the address shown on your ID card.

CIGNA will make a decision on your claim. For concurrent care claims, CIGNA will send you written notification of an affirmative benefit determination. For other types of claims, you may only receive written notice if CIGNA makes an **adverse benefit determination** (see next page).

Grievances and Appeals

The Plan has procedures for you to follow if you are dissatisfied with a decision that CIGNA has made or with the operation of the Plan. The process depends on the type of complaint you have. There are two categories of complaints:

- Quality of care or operational issues; and
- Adverse benefit determinations.

Complaints about quality of care or operational issues are called **grievances**. Complaints about adverse benefit determinations are called **appeals**.

Grievances

Quality of care or operational issues arise if you are dissatisfied with the service received from CIGNA or want to complain about a participating provider. To make a complaint about a quality of care or operational issue (called a grievance), call or write to Member Services within 30 days of the incident. Include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. CIGNA will review the information and provide you with a written decision within 30 calendar days of the receipt of the grievance, unless additional information is needed, but cannot be obtained within this time frame. The notice of the decision will specify what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations

Adverse benefit determinations are decisions CIGNA makes that result in denial, reduction, or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or service. Adverse benefit determinations can be made for one or more of the following reasons:

- The individual is not eligible to participate in the Plan; or
- CIGNA determines that a benefit or service is not covered by the Plan because:
 - It is not included in the list of covered benefits,
 - It is specifically excluded,
 - A Plan limitation has been reached, or
 - It is not medically necessary.

CIGNA will send you written notice of an adverse benefit determination. The notice will give the reason for the decision and will explain what steps you must take if you wish to appeal. The notice will also tell you about your rights to receive additional information that may be relevant to the appeal. Requests for appeal must be made in writing within 180 days from the receipt of the notice. However, appeals of adverse benefit determinations involving urgent care may be made orally.

The Plan provides for two levels of appeal, plus an option to seek external review of the adverse benefit determination. You must complete the two levels of appeal before bringing a lawsuit against the plan. If you are dissatisfied with the outcome of your level one appeal and wish to file a level two appeal, your appeal must be filed no later than 60 days following receipt of the level one notice of adverse benefit determination. The chart below summarizes some information about how appeals are handled for different types of claims.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to CIGNA. However, in case of an urgent care claim or a pre-service claim, a physician familiar with the case may represent you in the appeal.

Depending on the type of appeal, you and/or an authorized representative may attend the Level Two appeal hearing and question the representative of the Plan and any other witnesses, and present your case. The hearing will be informal. You may bring your physician or other experts to testify. The Plan also has the right to present witnesses.

If the Plan's appeals process upholds the original adverse benefit determination, you may have the right to pursue a State Health Benefits Commission review of your claim. See “Health Benefits Commission Appeal” on page 46 for more information.

Type of Claim	Level One Appeal: Response Time From Receipt of Appeal	Level Two Appeal: Response Time From Receipt of Appeal
<p>Urgent care claim: a claim for medical care or treatment where delay could:</p> <ul style="list-style-type: none"> • Seriously jeopardize your life or health, or your ability to regain maximum function; or • Subject you to severe pain that cannot be adequately managed without the requested care or treatment. 	<p>36 hours</p> <p>Review provided by Plan personnel not involved in making the adverse benefit determination.</p>	<p>36 hours</p> <p>Review provided by Plan personnel not involved in making the adverse benefit determination.</p>
<p>Pre-service claim: a claim for a benefit that requires approval of the benefit in advance of obtaining medical care.</p>	<p>15 calendar days</p> <p>Review provided by Plan personnel not involved in making the adverse benefit determination.</p>	<p>15 calendar days</p> <p>Review provided by Plan personnel not involved in making the adverse benefit determination.</p>
<p>Concurrent care claim extension: a request to extend a previously approved course of treatment.</p>	<p>Treated like an urgent care claim or a pre-service claim, depending on the circumstances.</p>	<p>Treated like an urgent care claim or a pre-service claim, depending on the circumstances.</p>
<p>Post-service claim: a claim for a benefit that is not a pre-service claim.</p>	<p>30 calendar days.</p> <p>Review provided by Plan personnel not involved in making the adverse benefit determination.</p>	<p>30 calendar days.</p> <p>Review provided by Plan personnel not involved in making the adverse benefit determination.</p>

Extensions of Time Frames

The time periods described in the chart (on page 44) may be extended.

For urgent care claims: If CIGNA does not have sufficient information to decide the claim, you will be notified as soon as possible (but no more than 24 hours after CIGNA receives the claim) that additional information is needed. You will then have at least 48 hours to provide the information. A decision on your claim will be made within 48 hours after the additional information is provided.

For non-urgent pre-service and post-service claims: The time frames may be extended for up to 15 additional days for reasons beyond the plan's control. In this case, CIGNA will notify you of the extension before the original notification time period has ended. If you fail to provide the information, your claim will be denied.

If an extension is necessary because CIGNA needs more information to process your post service claim, CIGNA will notify you and give you an additional period of at least 45 days after receiving the notice to provide the information. CIGNA will then inform you of the claim decision within 15 days after the additional period has ended (or within 15 days after CIGNA receives the information, if earlier). If you fail to provide the information, your claim will be denied.

How to File an Appeal

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

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

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

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

Health Benefit Commission Appeal

If dissatisfied with a final health plan decision on a medical appeal, only the member or the member's legal representative (this does not include the provider of service) may appeal, in writing, to the State Health Benefits Commission or the School Employees' Health Benefits Commission. If the member is deceased or incapacitated, the individual legally entrusted with his or her affairs may act on the member's behalf. Request for consideration must contain the reason for the disagreement along with copies of all relevant correspondence and should be directed to the following address:

**Appeals Coordinator
Division of Pensions and Benefits
PO Box 299
Trenton, NJ 08625-0299**

Notification of all Commission decisions will be made in writing to the member. If the Commission approves the member's appeal, the decision is binding upon the health plan. If the Commission denies the member's appeal, the member will be informed of further steps he or she may take in the denial letter from the Commission. Any member who disagrees with the Commission's decision may request, within 45 days in writing to the Commission that the case be forwarded to the Office of Administrative Law. The Commission will then determine if a factual hearing is necessary. If so the case will be forwarded to the Office of Administrative Law. An Administrative Law Judge (ALJ) will hear the case and make a recommendation to the Commission, which the Commission may adopt, modify, or reject. If the recommendation is rejected, the administrative appeal process is ended. When the administrative process is ended, further appeals will be made to the Superior Court of New Jersey, Appellate Division.

If your case is forwarded to the Office of Administrative Law, you will be responsible for the presentation of your case and for submitting all evidence. You will be responsible for any expenses involved in gathering evidence or material that will support your grounds for appeal. You will be responsible for any court filing fees or related costs that may be necessary during the appeal's process. If you require an attorney or expert medical testimony, you will be responsible for any fees or costs incurred.

Claim Fiduciary

The State Health Benefits Commission and the School Employees' Health Benefits Commission have complete discretionary authority to review all denied claims for benefits under the Plan. This includes, but is not limited to, determining whether hospital or medical treatment is, or is not, medically necessary. In exercising its responsibilities, the Commissions have discretionary authority to:

- Determine whether, and to what extent, you and your covered dependents are entitled to benefits; and
- Construe any disputed or doubtful terms of the Plan.

The Commissions have the right to adopt reasonable policies, procedures, rules and interpretations of the Plan to promote orderly and efficient administration. The Commissions may not abuse their discretionary authority by acting arbitrarily and capriciously.

The State Health Benefits Commission and the School Employees' Health Benefits Commission are responsible for making reports and disclosures required by applicable laws and regulations.

Subrogation and Right of Recovery Provision

Definitions

As used throughout this provision, the term "Responsible Party" means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition. The term "Responsible Party" includes the liability insurer of such party or any insurance coverage.

For purposes of this provision, the term "Insurance Coverage" refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

For purposes of this provision, a "Covered Person" includes anyone on whose behalf the Plan pays or provides any benefit including, but not limited to, the minor child or dependent of any Plan member or person entitled to receive any benefits from the Plan.

Subrogation

Immediately upon paying or providing any benefit under this Plan, and in a jurisdiction that permits subrogation, the Plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's injury, illness, or condition to the full extent of benefits provided or to be provided by the Plan.

Reimbursement

In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an injury, illness, or condition, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this Plan has paid and will pay as a result of that injury, illness, or condition, up to and including the full amount the Covered Person receives from any Responsible Party.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that if he or she receives any payment from any Responsible Party as a result of an injury, illness, or condition, he or she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the Plan.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for treatment of the illness, injury, or condition for which the Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise related to treatment for any illness, injury, or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the Covered Person, the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

First-Priority Claim

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person acknowledges that this Plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the Plan before any other claim for the Covered Person's damages. This Plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the Plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation

The Covered Person shall fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness, or condition sustained by the Covered Person. The Covered Person and his or her agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.

The Covered Person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

The Covered Person acknowledges that the Plan has the right to conduct an investigation regarding the injury, illness, or condition to identify any Responsible Party. The Plan reserves the right to notify the Responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

Rights and Responsibilities

Your Rights and Responsibilities

As a Plan participant, you have a right to:

- Get up-to-date information about the doctors and hospitals participating in the Plan.
- Obtain primary and preventive care from the Primary Care Physician you chose from the Plan's network.
- Change your Primary Care Physician to another available Primary Care Physician who participates in the CIGNA network.
- Obtain covered care from participating specialists, hospitals and other providers.
- Be referred to participating specialists who are experienced in treating your chronic illness.
- Be told by your doctors how to make appointments and get health care during and after office hours.
- Be told how to get in touch with your Primary Care Physician or a back-up doctor 24 hours a day, every day.
- Call 911 (or any available area emergency response service) or go to the nearest emergency facility in a situation that might be life-threatening.
- Be treated with respect for your privacy and dignity.

- Have your medical records kept private, except when required by law or contract, or with your approval.
- Help your doctor make decisions about your health care.
- Discuss with your doctor your condition and all care alternatives, including potential risks and benefits, even if a care option is not covered.
- Know that your doctor cannot be penalized for filing a complaint or appeal.
- Know how the Plan decides what services are covered.
- Know how your doctors are compensated for the services they provide. If you would like more information about CIGNA's physician compensation arrangements contact CIGNA Customer Service.
- Get up-to-date information about the services covered by the Plan — for instance, what is and is not covered and any applicable limitations or exclusions.
- Get information about copayments and fees you must pay.
- Be told how to file a complaint, grievance or appeal with the Plan.
- Receive a prompt reply when you ask the Plan questions or request information.
- Obtain your doctor's help in decisions about the need for services and in the grievance process.
- Suggest changes in the Plan's policies and services.

As a Plan participant, you have the responsibility to:

- Choose a Primary Care Physician from the Plan's network and form an ongoing patient-doctor relationship.
- Help your doctor make decisions about your health care.
- Tell your Primary Care Physician if you do not understand the treatment you receive and ask if you do not understand how to care for your illness.
- Follow the directions and advice you and your doctors have agreed upon.
- Tell your doctor promptly when you have unexpected problems or symptoms.
- Consult with your Primary Care Physician for non-emergency referrals to specialist or hospital care.
- See the specialists your Primary Care Physician refers you to.
- Make sure you have the appropriate authorization for certain services, including inpatient hospitalization and out-of-network treatment.
- Call your Primary Care Physician before getting care at an emergency facility, unless a delay would be detrimental to your health.
- Understand that participating doctors and other health care providers who care for you are not employees of CIGNA and that CIGNA does not control them.
- Show your ID card to providers before getting care from them.

- Pay the copayments required by the Plan.
- Call Member Services if you do not understand how to use your benefits.
- Promptly follow the Plan’s grievance procedures if you believe you need to submit a grievance.
- Give correct and complete information to doctors and other health care providers who care for you.
- Treat doctors and all providers, their staff, and the staff of the Plan with respect.
- Advise CIGNA about other medical coverage you or your family members may have.
- Not be involved in dishonest activity directed to the Plan or any provider.
- Read and understand your Plan and benefits. Know the copayments and what services are covered and what services are not covered.

Member Services

Member Services Department

Customer Service Professionals (CSPs) are trained to answer your questions and to assist you in using the Plan properly and efficiently.

Call the Member Services toll-free number on your ID card to:

- Ask questions about benefits and coverage;
- Notify CIGNA of changes in your name or telephone number;
- Change your Primary Care Physician; or
- Notify CIGNA about an emergency.

Please call your Primary Care Physician’s office directly with questions about appointments, hours of service or medical matters.

Internet Access

You can access CIGNA HealthCare on the Internet at: www.CIGNA.com/stateofnj

When you visit the Member Services site, you can:

- Find answers to common questions through: myCIGNA.com;
- Search for Primary Care Physicians; or
- Order a new ID card.

Patient Self-Determination Act (Advance Directives)

There may be occasions when you are not able to make decisions about your medical care. An Advance Directive can help you and your family members in such a situation.

What Is an Advance Directive?

An Advance Directive is generally a written statement that you complete in advance of serious illness that outlines how you want medical decisions made.

If you can't make treatment decisions, your physician will ask your closest available relative or friend to help you decide what is best for you. But there are times when everyone doesn't agree about what to do. That's why it is helpful if you specify in advance what you want to happen if you can't speak for yourself. There are several kinds of Advance Directives that you can use to say **what** you want and **whom** you want to speak for you. The two most common forms of an Advance Directive are:

- A Living Will; and
- A Durable Power of Attorney for Health Care.

What Is a Living Will?

A Living Will states the kind of medical care you want, **or do not want**, if you become unable to make your own decisions. It is called a Living Will because it takes effect while you are still living.

The Living Will is a document that is limited to the withholding or withdrawal of life-sustaining procedures and/or treatment in the event of a terminal condition. If you write a living will, give a copy to your Primary Care Physician.

What Is a Durable Power of Attorney for Health Care?

A Durable Power of Attorney for Health Care is a document giving authority to make medical decisions regarding your health care to a person that you choose. The Durable Power of Attorney is planned to take effect when you can no longer make your own medical decisions.

A Durable Power of Attorney can be specific to a particular treatment or medical condition, or it can be very broad. If you write a Durable Power of Attorney for Health Care, give a copy to your Primary Care Physician.

Who Decides About My Treatment?

Your physicians will give you information and advice about treatment. You have the right to choose. You can say "Yes" to treatments you want. You can say "No" to any treatment you don't want — even if the treatment might keep you alive longer.

How Do I Know What I Want?

Your physician must tell you about your medical condition and about what different treatments can do for you. Many treatments have side effects, and your doctor must offer you information about serious problems that medical treatment is likely to cause you. Often, more than one treatment might help you — and people have different ideas about which is best.

Your physician can tell you which treatments are available to you, but they can't choose for you. That choice depends on what is important to **you**.

How Does the Person Named in My Advance Directive Know What I Would Want?

Make sure that the person you name knows that you have an Advance Directive and knows where it is located. You might consider the following:

- If you have a Durable Power of Attorney, give a copy of the original to your “agent” or “proxy.” Your agent or proxy is the person you choose to make your medical decisions when you are no longer able.
- Ask your Primary Care Physician to make your Advance Directive part of your permanent medical record.
- Keep a second copy of your Advance Directive in a safe place where it can be found easily, if it is needed.
- Keep a small card in your purse or wallet that states that you have an Advance Directive and where it is located, and who your agent or proxy is, if you have named one.

Who Can Fill Out the Living Will or Advance Directive Form?

If you are 18 years or older and of sound mind, you can fill out this form. You do not need a lawyer to fill it out.

Whom Can I Name to Make Medical Treatment Decisions When I'm Unable to Do So?

You can choose an adult relative or friend you trust to be your agent or proxy, and to speak for you when you're too sick to make your own decisions.

There are a variety of living will forms available, or you can write your wishes on a piece of paper. If necessary, your doctor and family can use what you write to help make decisions about your treatment.

Do I Have to Execute an Advance Directive?

No. It is entirely up to you.

Will I Be Treated If I Don't Execute an Advance Directive?

Absolutely. We just want you to know that if you become too ill to make decisions, someone else will have to make them for you. With an Advance Directive, you can instruct others about your wishes before becoming unable to do so.

Can I Change My Mind After Writing an Advance Directive?

Yes. You may change your mind or cancel these documents at any time as long as you are competent and can communicate your wishes to your physician, your family and others who may need to know.

What Is the Plan's Policy Regarding Advance Directives?

We share your interest in preventive care and maintaining good health. Eventually, however, every family may face the possibility of serious illness in which important decisions must be made. We believe it is never too early to think about decisions that may be very important in the future and urge you to discuss these topics with your Primary Care Physician, family, friends, and other trusted, interested people.

You are not required to execute an Advance Directive.

If you choose to complete an Advance Directive, it is your responsibility to provide a copy to your physician and to take a copy with you when you check into a hospital or other health facility so that it can be kept with your medical records.

How Can I Get More Information About Advance Directives?

You can call Partnership for Caring at Choice in Dying, a community organization, at 1-800-989-9455.

CIGNA Standard Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice is effective on July 1, 2004.

CIGNA HealthCare¹ is committed to maintaining and protecting the confidentiality of our members' personal information. We are required by federal and state law to protect the privacy of your personal health information and other personal information about you. In this Notice, we will refer to this information as "confidential information." We also are required to send you this Notice about our policies, safeguards and practices. When we use or disclose your confidential information, we are bound by the terms of this Notice or our revised notice, if we revise it.

How We Protect Your Privacy

To provide you with health insurance benefits, CIGNA HealthCare receives confidential information from you and from other sources such as your health care providers, insurers and your employer. The information we receive includes personal health information as well as your name and address. CIGNA HealthCare will not disclose confidential information without your authorization unless it is necessary to provide your health benefits, administer your benefit plan, to support CIGNA HealthCare programs or services, or as otherwise required or permitted by law. When we need to disclose your confidential information, we will follow the policies described in this Notice to protect your privacy.

¹"CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc. In Arizona, HMO Plans are offered by CIGNA HealthCare of Arizona, Inc. In California, HMO plans are offered by CIGNA HealthCare of California, Inc. In Virginia, HMO plans are offered by CIGNA HealthCare of Virginia, Inc. and CIGNA HealthCare Mid-Atlantic, Inc. In North Carolina, HMO plans are offered by CIGNA HealthCare of North Carolina, Inc. All other medical plans in these states are insured or administered by Connecticut General Life Insurance Company.

CIGNA HealthCare locations that maintain confidential information have procedures for accessing, labeling and storing confidential records. Access to our facilities is limited to authorized personnel. We restrict internal access to your confidential information to CIGNA HealthCare employees who need to know that information to conduct our business. CIGNA HealthCare trains its employees on policies and procedures designed to protect your privacy.

Our Privacy Office monitors how we follow those policies and procedures and educates our organization on this important topic.

How We Use and Disclose Your Confidential Information

We will not use your confidential information or disclose it to others without your authorization, except for the following purposes:

- **Treatment.** We may disclose your confidential information to your doctors, hospitals and other health care providers for their provision, coordination or management of your health care and related services — for example, for coordinating your health care with us or for referring you to another provider for care.
- **Payment.** We may use and disclose your confidential information to obtain payment of premiums for your coverage and to determine and fulfill our responsibility to provide your health plan benefits — for example, to make coverage determinations, administer claims and coordinate benefits with other coverage you may have. We also may disclose your confidential information to another health plan or a health care provider for its payment activities — for example, for the other health plan to determine your eligibility or coverage, or for the health care provider to obtain payment for health care services provided to you.
- **Health Care Operations.** We may use and disclose your confidential information for our health care operations — for example, to provide customer service and conduct quality assessment and improvement activities. Other health operations may include providing appointment reminders or sending you information about treatment alternatives or other health-related benefits and services. We also may disclose your confidential information to another health plan or a provider who has a relationship with you, so that it can conduct quality assessment and improvement activities — for example, to perform case management.
- **Disclosure to Persons Involved in Your Care.** We may disclose confidential information about you or your child to persons who are involved in your or your child's care or payment for that care. For example, we might disclose confidential information about you to your spouse/civil union or domestic partner or confidential information about your child to your former spouse/partner who is the parent of your child. We will disclose only the information that is relevant to the care or payment. Callers will be asked to provide identifying information and, if they are asking about a claim, they will have to show knowledge of that claim before we will answer their questions. You have the right to stop or limit this kind of disclosure by requesting a restriction on the disclosure of your confidential information as described below under "Right to Request Additional Restrictions."
- **Disclosures to your Employer as Sponsor of Your Health Plan.** We may disclose your confidential information to your employer or to a company acting on your employer's behalf, so that it can monitor, audit and otherwise administer the employee health benefit plan in which you participate. Your employer is not permitted to use the confidential information we disclose for any purpose other than administration of your health benefit plan.

See your employer's health benefit plan documents for information on whether your employer receives confidential information and the identity of the employees who are authorized to receive your confidential information.

- **Disclosures to CIGNA HealthCare Vendors and Accreditation Organizations.** We may disclose your confidential information to companies with whom we contract if they need it to perform the services we've requested — for example, vendors who help us provide important information and guidance to members with chronic conditions like diabetes and asthma. CIGNA HealthCare also discloses confidential information to accreditation organizations such as the National Committee for Quality Assurance (NCQA) when the NCQA auditors collect Health Plan Employer Data and Information Set (HEDIS[®])² data for quality measurement purposes. When we enter into these types of arrangements, we obtain a written agreement to protect your confidential information.
- **Promotional Gifts.** We may use your confidential information or disclose it to a mailing vendor so that we may provide you with a promotional gift of nominal value such as a pen or a calendar. We will not disclose your confidential information to other companies for their marketing purposes.
- **Public Health Activities.** We may disclose your confidential information for the following public health activities and purposes: (1) to report health information to public health authorities that are authorized by law to receive such information for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse or neglect to a government authority that is authorized by law to receive such reports; (3) to report information about a product or activity that is regulated by the U.S. Food and Drug Administration (FDA) to a person responsible for the quality, safety or effectiveness of the product or activity; and (4) to alert a person who may have been exposed to a communicable disease, if we are authorized by law to give this notice.
- **Health Oversight Activities.** We may disclose your confidential information to a government agency that is legally responsible for oversight of the health care system or for ensuring compliance with the rules of government benefit programs, such as Medicare or Medicaid, or other regulatory programs that need health information to determine compliance.
- **For Research.** Under very limited circumstances, your confidential information may be used and disclosed for research without an authorization — for example, an authorization would not be necessary if your name, street address and other identifying information were removed.
- **To Comply with the Law.** We may use and disclose your confidential information to comply with the law.
- **Judicial and Administrative Proceedings.** We may disclose your confidential information in a judicial or administrative proceeding or in response to a legal order.
- **Law Enforcement Officials.** We may disclose your confidential information to the police or other law enforcement officials, as required by law or in compliance with a court order or other processes authorized by law.

² "HEDIS" is a registered trademark of the National Committee for Quality Assurance (NCQA).

- **Health or Safety.** We may disclose your confidential information to prevent or lessen a serious and imminent threat to your health or safety or the health and safety of the general public.
- **Government Functions.** We may disclose your confidential information to the U.S. military or to authorized federal officials for purposes specified by federal law.
- **Workers' Compensation.** We may disclose your confidential information when necessary to comply with Workers' Compensation laws.

Please note that should your coverage with CIGNA HealthCare terminate, we will continue to protect your confidential information. It will be used and disclosed only for the purposes described above and in accordance with the policies and procedures described in this Notice.

Uses and Disclosures with Your Written Authorization

We will not use or disclose your confidential information for any purpose other than the purposes described in this Notice without your written authorization. For example, we will not supply confidential information to another company for its marketing purposes or to a potential employer with whom you are seeking employment without your signed authorization. You may revoke an authorization that you previously have given by sending a written request to our Privacy Office, but not with respect to any actions we already have taken.

CIGNA HealthCare complies with state laws that place further restrictions on the disclosure of your personal health information without your authorization. For example, many states have laws that do not permit us to disclose a diagnosis of AIDS or mental illness. These laws have some limited exceptions.

Your Individual Rights

- **Right to Request Additional Restrictions.** You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this Notice. While we will consider all requests for restrictions carefully, we are not required to agree to a requested restriction.
- **Right to Receive Confidential Communications.** You may ask to receive communications of your confidential information from us by alternative means of communication or at alternative locations. While we will consider reasonable requests carefully, we are not required to agree to all requests.
- **Right to Inspect and Copy your Confidential Information.** You may ask to inspect or to obtain a copy of your confidential information that is included in certain records we maintain. Under limited circumstances, we may deny you access to all or a portion of your records. If you request copies, we may charge you copying and mailing costs.
- **Right to Amend your Records.** You have the right to ask us to amend your confidential information that is contained in certain records we maintain. If we determine that the record is inaccurate, and the law permits us to amend it, we will correct it. If your doctor or another person created the information that you want to change, you should ask that person to amend the information.
- **Right to Receive an Accounting of Disclosures.** Upon request, you may obtain an accounting of disclosures we have made of your confidential information. The accounting that

we provide will not include disclosures made before April 14, 2003, disclosures made for treatment, payment or health care operations, disclosures made earlier than six years before the date of your request, and certain other disclosures that are excepted by law. If you request an accounting more than once during any 12-month period, we will charge you a reasonable fee for each accounting statement after the first one.

- **Right to Receive Paper Copy of this Notice.** You may call Member Services at the toll-free number on your CIGNA HealthCare ID card to obtain a paper copy of this Notice, even if you previously agreed to receive this Notice electronically.

If you wish to make any of the requests listed above under "Individual Rights," you must complete and mail us the appropriate form. To obtain the form please visit our Web site at: www.CIGNA.com/general/misc/privacy.html and print the appropriate form. Or you can call Member Services at the toll-free number on your CIGNA HealthCare ID card to request the appropriate form. Forms should be mailed to the address printed on the forms. After we receive your signed, completed form, we will respond to your request.

- **For More Information or Complaints.** If you want more information about your privacy rights, do not understand your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your confidential information, you may contact our Privacy Office. You may also file written complaints with the Secretary of the U.S. Department of Health and Human Services. Please call our Privacy Office to obtain the correct address for the Secretary. We will not take any action against you if you file a complaint with the Secretary or us.

Privacy Office

You may contact our Privacy Office at:

**Privacy Office
CIGNA HealthCare
PO Box 5400
Scranton PA 18505**

Telephone Number: 1-800-762-9940
Fax Number: 1-860-226-9513

We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all of your confidential information that we maintain, including any information we created or received before we issued the new notice. If we change this Notice, we will send you the new notice if you are enrolled in a CIGNA HealthCare benefit plan at that time. In addition, we will post any new notice on our Web site at: www.CIGNA.com/general/misc/privacy.html. You also may obtain any new notice by calling Member Services at the toll-free number on your CIGNA HealthCare ID card.

Federal Notices

This section describes laws and plan provisions that apply to reproductive and women's health issues.

The Newborns' and Mothers' Health Protection Act

Federal law generally prohibits restricting benefits for hospital lengths of stay to less than 48 hours following a vaginal delivery and less than 96 hours following a caesarean section.

However, the plan may pay for a shorter stay if the attending provider (physician, nurse midwife or physician assistant) discharges the mother or newborn earlier, after consulting with the mother.

Also, federal law states that plan benefits may not, for the purpose of benefits or out-of-pocket costs, treat the later portion of a hospital stay in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Finally, federal law states that a plan may not require a physician or other health care provider to obtain authorization of a length of stay up to 48 hours or 96 hours, as described above. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification.

The Women's Health and Cancer Rights Act

In accordance with the Women's Health and Cancer Rights Act, this Plan covers the following procedures for a person receiving benefits for an **appropriate** mastectomy:

- Reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to create a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply to the mastectomy.

For answers to questions about the plan's coverage of mastectomies and reconstructive surgery, call CIGNA's Member Services at the number shown on your ID card.

Plan Information

Amendment or Termination of the Plan

The State of New Jersey has the right to amend or terminate the Plan, in whole or in part, at any time. If a change is made, you will be notified.

The establishment of an employee benefit plan does not imply that employment is guaranteed for any period of time or that any employee receives any nonforfeitable right to continued participation in any benefits plan.

Plan Documents

This plan description covers the features of the HMO Plan administered by CIGNA Health Plans, Inc. effective April 1, 2008.

Provider Termination

When we know a PCP is leaving our network, we make a good faith effort to notify affected members by mail within 30 days. Our letter advises the member to choose a new PCP. If needed, we will assist members in selecting a new PCP. To select a new PCP, members can call the toll-free member services number on their ID card or visit our Web site at: www.CIGNAhealth.com.

Required Documentation for Dependent Eligibility and Enrollment

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

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

Specific required documents are detailed in the chart on page 61.

Required Documentation for Dependent Eligibility and Enrollment

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

Continued on next page

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

Required Documentation for Dependent Eligibility and Enrollment

Dependent	Eligibility Definition	Required Documentation
Children	<p>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.</p> <p>This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation.</p> <p>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).</p>	<p>Natural or Adopted Child – A photocopy of the child’s birth certificate showing the name of the employee/retiree as a parent.</p> <p>Step Child – A photocopy of the child’s birth certificate showing the name of the employee/retiree’s spouse or partner as a parent and a photocopy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner.</p> <p>Legal Guardian, Grandchild, or Foster Child – Photocopies of Final Court Orders with the presiding judge’s signature and seal. Documents must attest to the legal guardianship by the covered employee.</p>
Dependent Children With Disabilities	<p>If a covered child is not capable of self-support when he or she reaches age 26 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuance of coverage.</p> <p>See “Dependent Children with Disabilities” on page 30 for additional information. You will be contacted periodically to verify that the child remains eligible for continued coverage.</p>	<p>Documentation for the appropriate “Child” type (as noted above) and a photocopy of the front page of the employee/retiree’s most recently filed federal tax return* (<i>Form 1040</i>) that includes the child.</p> <p>If Social Security disability has been awarded, or is currently pending, please include this information with the documentation that is submitted.</p> <p>Please note that this information is only verifying the child’s eligibility as a dependent. The disability status of the child is determined through a separate process.</p>
Continued Coverage for Over Age Children	<p>Certain children over age 26 may be eligible for continued coverage until age 31 under the provisions of Chapter 375, P.L. 2005. See “Over Age Children until Age 31” on page 36 for additional information.</p>	<p>Documentation for the appropriate “Child” type (as noted above), and a photocopy of the front page of the child’s most recently filed federal tax return* (<i>Form 1040</i>), and if the child resides outside of the State of New Jersey, documentation of full time student status must be submitted.</p>

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

Glossary

Chronic Condition – A disease or ailment of long duration or frequent recurrence. When a condition is neither regressing nor improving, or maximum therapeutic benefit has been achieved, or substantial further improvement is unlikely in the short term, then it is considered chronic in nature. Therapy for a chronic condition may be excluded from coverage (see also Maintenance Care).

Civil Union Partner – A person of the same sex with whom you have entered into a civil union. A photocopy of the *New Jersey Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions and additional supporting documentation are required for enrollment. The cost of civil union partner coverage may be subject to federal tax (see your employer or [Fact Sheet #75](#), *Civil Unions*, for details).

Copayment – The fee that must be paid by a Plan participant to a participating provider at the time of service for certain covered expenses and benefits, as described in the “Copayment Schedule.”

Cosmetic Surgery – Any surgery or procedure that is not medically necessary and whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not:

- Restore bodily function;
- Correct a diseased state, physical appearance or disfigurement caused by an accident or birth defect; or
- Correct or naturally improve a physiological function.

Covered Services and Supplies (covered expenses) – The types of medically necessary services and supplies described in “Your Benefits.”

Custodial Care – Services that do not require the skill level of a nurse to perform. These services include but are not limited to assisting with activities of daily living, meal preparation, ambulation, cleaning, and laundry functions. Custodial care services are not eligible for coverage, including those that are considered to be medically needed.

Detoxification – The process whereby an alcohol-intoxicated, alcohol-dependent or drug-dependent person is assisted in a facility licensed by the state in which it operates, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factor, or alcohol in combination with drugs as determined by a licensed physician, while keeping physiological risk to the patient at a minimum.

Domestic Partner – A person of the same sex with whom you have entered into a domestic partnership as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act. The domestic partner of any State employee, State retiree, or an eligible employee or retiree of a participating local public entity that adopts a resolution to provide Chapter 246 health benefits, is eligible for coverage. A photocopy of the *New Jersey Certificate of Domestic Partnership* dated prior to February 19, 2007 (or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners) and additional supporting documentation are required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer or [Fact Sheet #71](#), *Benefits Under the Domestic Partnership Act*, for details)

Durable Medical Equipment (DME) – Equipment determined to be:

- Designed and able to withstand repeated use;
- Made for and used primarily in the treatment of a disease or injury;
- Generally not useful in the absence of an illness or injury;
- Suitable for use while not confined in a hospital;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Emergency – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or a guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily function.
- Serious dysfunction of bodily organ or part.

Claims will be paid for emergency services furnished in a hospital emergency department if the presenting symptoms reasonably suggested an emergency condition as would be interpreted by a prudent layperson. All procedures performed during the evaluation (triage) and treatment of an emergency condition will be covered.

Employer – The State or a local public employer which participates in the State Health Benefits Program, or a local educational employer which participates in the School Employees' Health Benefits Program.

Experimental or Investigational – Services or supplies that are determined by CIGNA to be experimental. A drug, device, procedure or treatment will be determined to be experimental if:

- There are not sufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- Required FDA approval has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
- The written protocol(s) used by the treating facility or the protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or

- It is not of proven benefit for the specific diagnosis or treatment of your particular condition; or
- It is not generally recognized by the medical community as effective or appropriate for the specific diagnosis or treatment of your particular condition; or
- It is provided or performed in special settings for research purposes.

Home Health Services – Those items and services provided by participating providers as an alternative to hospitalization, and approved and coordinated in advance by CIGNA.

Hospice Care – A program of care that is:

- Provided by a hospital, skilled nursing facility, hospice or duly licensed hospice care agency;
- Approved by CIGNA; and
- Focused on palliative rather than curative treatment for a Plan participant who has a medical condition and a prognosis of less than 6 months to live.

Hospital – The term Hospital means:

- An institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;
- An institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or an institution which: (a) specializes in treatment of Mental Health and Substance Abuse or other related illness; and (b) is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

Infertility – Means you are not able to:

- Impregnate another person;
- Conceive after two years if the female partner is under 35 years old, or after one year if the female partner is 35 years old or older, or if one partner is considered medically sterile; or
- Carry a pregnancy to live birth.

Local Employee – For purposes of health benefits coverage, a local employee is a full-time employee receiving a salary and working for a Participating Local Employer. Full-time shall mean employment of an eligible employee who appears on a regular payroll and who receives salary or wages for an average number of hours specified by the employer, but not to be less than 20 hours per week. It also means employment in all 12 months of the year except in the case of those employees engaged in activities where the normal work schedule is 10 months. In addition, for local coverage, employee shall also mean an appointed or elected officer of the local employer, including an employee who is compensated on a fee basis as a convenient method of payment of wages or salary but who is not a self-employed independent contractor compensated in a like manner. To qualify for coverage as an appointed officer, a person must be appointed to an office specifically established by law, ordinance, resolution, or such other official action

required by law for establishment of a public office by an appointing authority. A person appointed under a general authorization, such as to appoint officers or to appoint such other officers or similar language is not eligible to participate in the program as an appointed officer. An officer appointed under a general authorization must qualify for participation as a full-time employee.

Local Employer – Government employers in New Jersey, including counties, municipalities, townships, school districts, community colleges, and various public agencies or organizations.

Maintenance Care – Care that when provided does not substantially improve the condition. When care is provided for a condition that has reached maximum improvement and further services will not appreciably improve the condition care will be deemed to be maintenance care and no longer eligible for coverage.

Medical Services – Those professional services of physicians or other health professionals, including medical, surgical, diagnostic, therapeutic and preventive services authorized by CIGNA.

Medically Necessary – Services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards, as described in the “Your Benefits” section of this member handbook. To be medically necessary, the service or supply must:

- Be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition;
- Be care or services related to diagnosis or treatment of an existing illness or injury, except for covered periodic health evaluations and preventive and well-baby care, as determined by CIGNA;
- Be a diagnostic procedure, indicated by the health status of the Plan participant, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition;
- Include only those services and supplies that cannot be safely and satisfactorily provided at home, in a physician’s office, on an outpatient basis, or in any facility other than a hospital, when used in relation to inpatient hospital services; and
- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the tests described above.

In determining whether a service or supply is medically necessary, CIGNA will consider:

- Information provided on your health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;

- The opinion of health professionals in the generally recognized health specialty involved;
- The opinion of the attending physicians, which has credence but does not overrule contrary opinions; and
- Any other relevant information brought to CIGNA's attention.

In no event will the following services or supplies be considered medically necessary:

- Services or supplies that do not require the technical skills of a medical, mental health or dental professional;
- Custodial care, supportive care or rest cures;
- Services or supplies furnished mainly for the personal comfort or convenience of the patient, any person caring for the patient, any person who is part of the patient's family or any health care provider;
- Services or supplies furnished solely because the Plan participant is an inpatient on any day when their disease or injury could be diagnosed or treated safely and adequately on an outpatient basis;
- Services furnished solely because of the setting if the service or supply could be furnished safely and adequately in a physician's or dentist's office or other less costly setting; or
- Experimental services and supplies, as determined by CIGNA.

Medicare – The federal health insurance program for people 65 or older, people of any age with permanent kidney failure, and certain disabled people under age 65. Medical coverage consists of two parts: Part A is Hospital Insurance Benefits and Part B is Medical Insurance Benefits. A retired group member and/or spouse, civil union partner, or eligible same-sex domestic partner who is eligible for Medicare coverage by reason of age or disability must be enrolled in Parts A and B to enroll or remain in Retired Group coverage.

Mental or Nervous Condition – A condition which manifests signs and/or symptoms that are primarily mental or behavioral, for which the primary treatment is psychotherapy, psychotherapeutic methods or procedures, and/or the administration of psychotropic medication. Mental or behavioral disorders and conditions include, but are not limited to:

- Psychosis;
- Affective disorders;
- Anxiety disorders;
- Personality disorders;
- Obsessive-compulsive disorders;
- Attention disorders with or without hyperactivity; and
- Other psychological, emotional, nervous, behavioral or stress-related abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems, whether or not caused or in any way resulting from chemical imbalance, physical trauma, or a physical or medical condition.

Outpatient – This is:

- A Plan participant who is registered at a practitioner’s office or recognized health care facility, but not as an inpatient; or
- Services and supplies provided in such a setting.

Partial Hospitalization – Medical, nursing, counseling and therapeutic services provided on a regular basis to a Plan participant who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care. Services must be provided in a hospital or non-hospital facility that is licensed as an alcohol, drug abuse or mental illness treatment program by the appropriate regulatory authority. Defined as not less than 4 hours and not more than 12 hours in any 24-hour period. The exchange for services will be two partial hospitalization sessions are equal to one day of inpatient care.

Participating Provider – A provider that has entered into a contractual agreement with CIGNA to provide services to Plan participants.

Physician – A member of a medical profession, who is properly licensed or certified to provide medical care under the laws of the state where they practice, and who provides medical services which are within the scope of their license or certificate.

Plan Benefits – Medical services, hospital services, and other services and care to which a Plan participant is entitled, as described in this member handbook.

Plan Participant – A member enrolled in the CIGNA HMO.

Primary Care Physician – A participating physician who supervises, coordinates, and provides initial care and basic medical services as a general or family care practitioner or, in some cases, as an internist or a pediatrician, to Plan participants; initiates their referral for specialist care; and maintains continuity of patient care.

Provider – This term is used to define an eligible provider and includes medical doctors, dentists, podiatrists, acupuncturists, psychologists, psychiatrists, nurse midwives, licensed clinical social workers, licensed marriage and family therapists, licensed professional counselors, chiropractors, certified nurse practitioners, clinical nurse specialists, physical therapists, occupational therapists, optometrists, and audiometrists who are properly licensed and are working within the scope of their practice.

Referral – Specific written or electronic direction or instruction from a Plan participant’s primary care physician, in conformance with CIGNA’s policies and procedures, which directs the Plan participant to a participating provider for medically necessary care.

Respite Care – Care provided during a period of time when the insured’s usual caregiver is not attending to the insured.

School Employees’ Health Benefits Commission – The entity created by N.J.S.A. 52:14-17.46 and charged with the responsibility of overseeing the School Employee’s Health Benefits Program.

School Employees' Health Benefits Program (SEHBP) – The SEHBP was established by Chapter 103, P.L. 2007. It offers medical and prescription drug coverage to qualified school employees and retirees, and their eligible dependents. Local employers must adopt a resolution to participate in the SEHBP. The School Employees' Health Benefits Program Act is found in the N.J.S.A. 52:14-17.46 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

SEHBP Member – An individual who is either a School Employees' Health Benefits Program Active Group, Retired Group, or COBRA participant and their dependents.

Service Area – The geographic area, established by CIGNA and approved by the appropriate regulatory authority, in which a Plan participant must live or work or otherwise meet the eligibility requirements in order to be eligible as a participant in the Plan.

SHBP Member – An individual who is either a State Health Benefits Program Active Group, Retired Group, or COBRA participant and their dependents.

Skilled Nursing Facility – An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a skilled nursing facility, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by CIGNA to meet the reasonable standards applied by any of the aforesaid authorities.

Specialist – A physician who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

Spouse — A member of the opposite sex to whom you are legally married. A photocopy of the marriage certificate and additional supporting documentation are required for enrollment.

State Health Benefits Commission (Commission) – The entity created by N.J.S.A. 52:14-17.27 and charged with the responsibility of overseeing the State Health Benefits Program.

State Health Benefits Program (SHBP) – The SHBP was established in 1961. It offers medical, prescription drug, and dental coverage to qualified public employees and retirees, and their eligible dependents. Local employers must adopt a resolution to participate in the SHBP. The State Health Benefits Program Act is found in the N.J.S.A. 52:14-17.25 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

State Monthly Employer – Employers whose benefits are based on a monthly cycle and whose payroll system is autonomous (not paid by the State's centralized payroll system). This includes state colleges and universities and participating independent state commissions, authorities, and agencies such as:

- Rutgers, the State University of New Jersey
- Palisades Interstate Park Commission
- New Jersey Institute of Technology
- University of Medicine & Dentistry of NJ
- Thomas A. Edison State College

- William Paterson University
- Ramapo State College
- Rowan University
- College of New Jersey
- Montclair State University
- New Jersey City University
- Kean University
- Stockton State College
- New Jersey State Library
- New Jersey State legislature and legislative offices
- New Jersey Building Authority
- New Jersey Commerce and Economic Growth Commission
- Waterfront Commission of New York Harbor
- Agencies or special projects that are supported from, or whose employees are paid from, sources of revenue other than general funds, which other funds shall bear the cost of benefits under this program.

Substance Abuse – Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal.

Supportive Care – Treatment for patients having reached maximum therapeutic benefit in whom periodic trials of therapeutic withdrawals fail to sustain previous therapeutic gains.

Terminal Illness – An illness of a Plan participant, which has been diagnosed by a physician and for which they have a prognosis of six (6) months or less to live.

Urgent Medical Condition – A medical condition for which care is medically necessary and immediately required because of unforeseen illness, injury or condition, and it is not reasonable, given the circumstances, to delay care in order to obtain the services through your home service area or from your Primary Care Physician.

Waiting Period – The period of time between enrollment in the State Health Benefits Program or the School Employees' Health Benefits Program and the date when you become eligible for benefits.

Plans and benefits are subject to and governed by the terms (including exclusions and limitations) of the agreement between CIGNA Life Insurance Company, the New Jersey State Health Benefits Commission, and the New Jersey School Employees' Health Benefits Commission. The information herein is believed accurate as of the date of publication and is subject to change without notice.

