

**STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS**



***RETIREE
DENTAL EXPENSE
PLAN***

***MEMBER
HANDBOOK***

**For Retired Group Members of the
State Health Benefits Program
and
School Employees' Health Benefits Program**

**Administered by
Aetna**

Plan Year 2011

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INTRODUCTION

The State Health Benefits Program (SHBP) was established in 1961. It offers medical and prescription drug coverage to qualified State and local government public employees, retirees, and eligible dependents; and dental coverage to qualified State and local government/education public employees, retirees, and their eligible dependents. Local employers must adopt a resolution to participate in the SHBP.

The State Health Benefits Commission (SHBC) is the executive organization responsible for overseeing the SHBP.

The State Health Benefits Program Act is found in the New Jersey Statutes Annotated, Title 52, Article 17.25 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

The School Employees' Health Benefits Program (SEHBP) was established in 2007. It offers medical and prescription drug coverage to qualified local education public employees, retirees, and eligible dependents. Local education employers must adopt a resolution to participate in the SEHBP.

The School Employees' Health Benefits Commission (SEHBC) is the executive organization responsible for overseeing the SEHBP.

The School Employees' Health Benefits Program Act is found in the New Jersey Statutes Annotated, Title 52, Article 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.

The Division of Pensions and Benefits, specifically the Health Benefits Bureau and the Bureau of Policy and Planning, are responsible for the daily administrative activities of the SHBP and the SEHBP.

The Retiree Dental Expense Plan is available to retirees eligible for enrollment in the SHBP or the SEHBP. The plan has been established by the State as a self-insured plan. The State contracts with a claims administrator, Aetna, to act as the administrative agent for the plan. Before making any enrollment decision, you should carefully review the standards of eligibility and the conditions, limitations, and exclusions of the coverage offered under the plan.

Every effort has been made to ensure the accuracy of the *Retiree Dental Expense Plan Member Handbook*. However, State law and the New Jersey Administrative Code govern the SHBP and SEHBP. If there are discrepancies between the information presented in this booklet and/or plan documents and the law, regulations, or contracts, the law, regulations, and contracts will govern. Furthermore, if you are unsure whether a dental service or procedure is covered, contact your dental plan before you receive services to avoid any denial of coverage issues that could result.

If, after reading this booklet, you have any questions, comments, or suggestions regarding the information presented, please write to the Division of Pensions and Benefits, PO Box 295, Trenton, NJ 08625-0295, call (609) 292-7524, or send e-mail to: pensions.nj@treas.state.nj.us



RETIREE DENTAL EXPENSE PLAN ELIGIBILITY

ELIGIBLE RETIREES

Enrollment in the Retiree Dental Expense Plan is voluntary. You have one opportunity to enroll in the Retiree Dental Expense Plan when you first become eligible for Retired Group SHBP or SEHBP health plan coverage. **A retiree must submit a SHBP/SEHBP Retired Coverage Enrollment Application within 60 days of retirement or when first eligible for enrollment or lose the ability to enroll** (except as specifically stated below under “Waiver of Enrollment for Other Dental Coverage”).

The Retiree Dental Expense Plan is available to the following:

- Any retiree, including surviving eligible dependents, enrolled in a health plan in the Retired Group of the SHBP or SEHBP.
- Any retiree, including surviving eligible dependents, eligible for enrollment in the Retired Group of the SHBP or SEHBP but who elected to waive their medical coverage because of other SHBP or SEHBP coverage or group coverage provided from another employer — either as a dependent of a spouse, civil union, or same-sex domestic partner or through their own employment.

COBRA Members

Employees enrolled in the SHBP or SEHBP who elect at retirement to continue their employee dental plan coverage under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) will not be eligible to enroll in the Retiree Dental Expense Plan when their COBRA eligibility period ends. They must choose to enroll in the Retiree Dental Expense Plan within 60 days of retirement or when first eligible for enrollment or lose the ability to enroll.

Waiver of Enrollment for Other Dental Coverage

The one time dental plan enrollment opportunity can be deferred if an otherwise eligible individual has other group dental coverage as either a dependent of a spouse, civil union partner, or domestic partner, or through their own employment under an employer plan, or through a eligible retiree group association. An eligible retiree group association is an association whose membership is limited based on the former employment of the retiree or retiree’s dependent.

A retiree or eligible survivor may elect to waive enrollment at the time of retirement or first offering and retain their right to enroll at a later date. The individual must request enrollment within 60 days from the loss of the other group dental coverage by contacting the Division of Pensions and Benefits to request an enrollment application.

Proof of the other group dental plan termination of coverage must be submitted in the form of a *HIPAA Certification of Coverage* form or a letter from the employer along with the *Retired Coverage Enrollment Application*.

ELIGIBLE DEPENDENTS

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

Spouse — This is a member of the opposite sex to whom you are legally married. A photocopy of the marriage certificate and additional supporting documentation are required when enrolling your spouse for the first time in the SHBP.

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).

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).

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.

Stepchildren, foster children, legally adopted children, and children in a guardian-ward relationship are also eligible. Legal documentation is required with enrollment forms for these cases. Documents must attest to the legal guardianship by the covered employee.

Coverage for an enrolled child will end when the child turns age 26. Coverage for children age 26 ends on December 31 of the year in which they turn age 26 (see page 20 for limited “Extension of Coverage Provisions”).

Note: that the extension of coverage is only available if the adult child is not eligible to enroll in other employer-based coverage (aside from coverage through the parent).

Dependent Children with Disabilities — If a covered child is not capable of self-support when he or she reaches age 26 due to mental illness, 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, 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. You will be contacted periodically to verify that the child remains eligible for continued coverage.

Please Note: Extended coverage provisions under Chapter 375, P.L. 2005, for certain over age children **and** the extension of coverage under the provisions of federal COBRA law do not apply to the Retiree Dental Expense Plan. When Retiree Dental Expense Plan coverage ends for yourself or your dependents (except as described above), there are no other provisions for extending coverage.

RETIREE DENTAL EXPENSE PLAN

GENERAL CONDITIONS OF THE PLAN

The Retiree Dental Expense Plan is a PPO plan that will reimburse you for a portion of the expenses you, and your enrolled eligible dependents, incur for dental care provided by dentists or physicians licensed to perform dental services in the state in which they are practicing. Not all dental services are eligible for reimbursement and some services are eligible only up to a limited amount.

Deductibles

Diagnostic and preventive services are not subject to an annual deductible amount. For all other services, an annual deductible amount of \$50 of covered expenses that you or each of your dependent(s) incur in a calendar year is not eligible for reimbursement. However, if there are three or more members of your family enrolled in the plan, no additional deductibles are charged for the calendar year after a total of \$150 in eligible expenses. Charges incurred in a dental plan prior to your enrollment in this Plan will not count towards your annual deductible.

After any applicable annual deductible is satisfied, you are reimbursed a percentage of the negotiated discounted fee for in-network services or reasonable and customary allowance for out-of-network services that are covered under the plan.

Discounted Fee for Service Network

It is recommended that you take advantage of a special network of participating dental providers who discount their fees for services. When you use a participating dental provider, you only pay the provider any applicable deductible and the appropriate coinsurance based on the discounted fee, thereby reducing your out-of-pocket cost. In most cases the participating dental provider will submit the claims directly for you, eliminating the necessity of your filing claim forms. Out-of-network dentists do not need to file claims on your behalf and you may be responsible for submitting a claim form directly to Aetna. In some cases an out-of-network dentist may ask you to pay your bill in full and ask you to submit the claim for reimbursement. To find out if your provider participates in the discounted network, contact Aetna, toll-free, at: 1-877-238-6200, or visit the Aetna Web site at: www.aetna.com/docfind/custom/statenj

Reasonable and Customary Allowance

The reasonable and customary allowance only applies to out-of-network services. When utilizing an out-of-network provider, the plan covers only that part of a provider's fee for a service or supply that is reasonable and customary. Generally speaking, a fee charged by your dentist, or by any other provider of services or supplies, is considered reasonable and customary if it doesn't exceed the prevailing fee charged for the same

service or supply by similar providers in the same geographic area. The prevailing allowance used for this plan is provided by Ingenix (a national database of dental plan services and fees) and may differ from the actual amount the your dentist charges. If your dentist charges more than the reasonable and customary allowance, you are responsible for the amount above the reasonable and customary allowance unless a participating dental provider is used.

Reimbursement

After a member meets his or her \$50 annual deductible (if applicable), the costs of all other eligible services for that person are reimbursed at a percentage of the reasonable and customary allowance for the service.

Annual Benefit Maximum

The most the plan will pay for any one person in any calendar year is \$1,500. This maximum applies to all eligible services.

PLAN DESIGN

THREE TIER BENEFIT DESIGN

The Retiree Dental Expense Plan features three benefit tiers (see chart on page 8). Your initial benefit tier depends upon whether you were covered under a group dental plan just prior to your enrollment.

- If you, the retiree, were covered under a group dental plan for at least one year within 60 days of joining this plan, you and your eligible dependents will be enrolled at the highest level of benefits — **Tier Three**. Specific information concerning the 12-month dental plan enrollment must be provided on your enrollment application.
- If you, the retiree, were not covered under a group dental plan for at least one year within 60 days of joining this plan, you and your eligible dependents will be enrolled at the lowest level of reimbursement — **Tier One**. Each year you remain a member of the plan, your reimbursement benefit will rise to a higher tier until you are at the top level of benefits (Tier Three).

COVERED SERVICES

The Retiree Dental Expense Plan covers **preventive care, basic services, and major restorative** services at different levels. The deductible is waived for preventive care. The Retiree Dental Expense Plan does not reimburse for any orthodontic services. A general description of each category of service follows.

Preventive Care

Preventive care consists of diagnostic and preventive services that are precautionary services intended to maintain oral health and reduce the effects of tooth decay or gum disease that could lead to an increased need for more costly restorative services. They include the following:

- Oral Evaluations (includes comprehensive, periodic, and problem focused oral evaluations);
- Prophylaxis (cleaning of the teeth, including the removal of plaque, calculus, and stains from tooth structures, limitations apply - see page 11);
- Fluoride Treatments (topical application of fluoride for children under age 19);
- X-rays (limitations apply - see page 11); and
- Laboratory and other Dental Diagnostic Tests.

Basic Services

Basic services include:

- Emergency Treatment (Palliative only);
- Space Maintainers (i.e., passive appliances - can be fixed or removable);
- Simple Extractions;
- Surgical Extractions;
- Oral Surgery;
- Anesthesia Services;
- Basic Restorations (i.e., amalgam restorations and resin-based composite restorations);
- Endodontics (i.e., treatment of diseases of the dental pulp, including root canal and associated therapy); and
- Repairs to removable and fixed dentures.

RETIREE DENTAL EXPENSE PLAN REIMBURSEMENT TIERS				
	ANNUAL DEDUCTIBLE	COINSURANCE		MAXIMUM ANNUAL BENEFIT
<u>TIER 1</u>	\$50 per person, but not more than \$150 total; waived for Preventative Care	<u>IN-NETWORK</u> 80% - Preventative Care 50% - Basic Restorative 30% - Major Restorative	<u>OUT-OF-NETWORK</u> 70% - Preventative Care 50% - Basic Restorative 20% - Major Restorative	\$1,500 per person
<u>TIER 2</u>	\$50 per person, but not more than \$150 total; waived for Preventative Care	<u>IN-NETWORK</u> 90% - Preventative Care 60% - Basic Restorative 40% - Major Restorative	<u>OUT-OF-NETWORK</u> 80% - Preventative Care 50% - Basic Restorative 30% - Major Restorative	\$1,500 per person
<u>TIER 3</u>	\$50 per person, but not more than \$150 total; waived for Preventative Care	<u>IN-NETWORK</u> 100% - Preventative Care 70% - Basic Restorative 50% - Major Restorative	<u>OUT-OF-NETWORK</u> 90% - Preventative Care 50% - Basic Restorative 40% - Major Restorative	\$1,500 per person

Major Restorative Services

Major restorative services include those services that restore existing teeth. These services are utilized only if a tooth cannot be restored with an amalgam, acrylic, synthetic porcelain, or composite filling restoration. Inlays, onlays, and crowns are typical examples of major restorative services.

Other Major Restorative services include:

- **Periodontal** services include those services involving the maintenance, reconstruction, regeneration, and treatment of the supporting structures surrounding teeth, including bone, gum tissue, and root surfaces.
- **Prosthodontic** services include both removable and fixed dentures (bridges) replacing missing teeth.

Note: Orthodontic services are not covered under the Retiree Dental Expense Plan.

ADDITIONAL PROVISIONS OF THE PLAN

How Payments are Made

If you use a participating dental network provider, payments are made directly to the provider less any applicable deductible or appropriate coinsurance based on the discounted fee (see page 5).

If you use a non-participating provider, the provider may ask you to pay for the service in advance. If the provider's office asks you to pre-pay for the services it will be your responsibility to submit the claim to Aetna for reimbursement. The retiree may, however, authorize Aetna to send the reimbursement directly to the dental provider by completing the appropriate section of the claim form. Additionally, whenever a law or court order requires the payment of dental expense benefits under the plan to be made to a person or facility other than the retiree, the payment will be made to that person or facility upon proper notification (letter and a copy of the order/law).

Filing Deadline — Proof of Loss

Aetna must be given written proof that a dental service has been performed for which a claim is made under the coverage. This proof must cover the occurrence, character, and extent of the service. It must be furnished within 27 months of the date of service. For example, if a service were incurred in February 1, 2010, you would have until April 30, 2013 to file the claim.

A claim will not be considered valid unless proof of the service is furnished within the time limit indicated above. If it is not possible for you to provide proof within the time limit, the claim may be considered valid upon appeal if the reason the proof was not provided in a timely basis was reasonable.

Itemized Bills are Necessary

You must obtain itemized bills from the providers of services for all dental expenses. The itemized bills must include the following:

- Name and address of provider
- Provider's tax identification number
- Name of patient
- Subscriber's identification number
- Date of service
- Type of service
- Procedure code (CDT — 2011 Code)
- Charge for each service

Predetermination of Benefits

Predetermination is voluntary and allows you to know what services are covered and what payments will be made for treatment before the work is done. If you or one of your dependents are likely to incur dental expenses over \$300, it is strongly recommended that you ask your dentist to file for predetermination of benefits.

This feature of the Retiree Dental Expense Plan ensures that both you and the dentist will know in advance what part of the dentist's charges the plan will pay. If possible, treatment should be completed within 90 days of receiving the approved predetermination.

The predetermination of benefits provision of the Retiree Dental Expense Plan is important, because under the alternative procedures provision (see “Alternative Procedures”, below), Aetna has the right to pay the reasonable and customary allowance for the method of treatment that is proper and is economically sound.

How Predetermination of Benefits Works — Your dentist submits a treatment plan and Aetna determines the amount the Retiree Dental Expense Plan will pay and informs you and the dentist of its payment decision. You and your dentist should discuss the payment before the work is started.

Predetermination of benefits will help you avoid surprises. Most dentists are familiar with predetermination procedures, but if not, they should call Aetna at 1-877-238-6200. If your dentist submits a treatment plan for predetermination of benefits and then alters the course of treatment, Aetna will adjust its payments accordingly. If the dentist makes a major change in the treatment plan, he or she should send in a revised plan.

Alternative Procedures

Usually there are several ways to treat a particular dental problem. Payment will be based on the least costly treatment so long as the result meets acceptable dental standards. If you and the dentist decide you want a more costly treatment method, you are responsible for the charges beyond those for the less costly, appropriate treatment.

SERVICES THAT ARE ELIGIBLE FOR REIMBURSEMENT

See the Glossary on page 23 for a definition of terms.

- Oral evaluations covered at 80%, 90%, or 100% in-network, or at 70%, 80%, or 90% out-of-network depending on your benefit tier (limited to twice in a calendar year). Emergency or limited oral evaluations are covered, limited to one evaluation per patient, per year. Periodontal maintenance evaluations are included as oral evaluations.
- X-rays (horizontal bitewing X-rays limited to two series of up to four films in a calendar year; vertical bitewing X-rays limited to two series of up to eight films in a calendar year; set of full mouth or panoramic X-rays limited to once per 36 month interval; no more than 18 films per set of full mouth periapical X-rays).
- Oral prophylaxis, including the removal of plaque, calculus, and stains from tooth structures (not including scaling performed by a periodontist) and polishing (limited to twice in a calendar year).
- Topical application of fluoride for children under age 19 limited to twice in a calendar year.
- Prosthodontic procedures (the replacement of an existing fixed or removable prosthetic appliance is covered only after a five-year period measured from the date on which the appliance was previously placed).
- Periodontics procedures (reimbursement for periodontal surgical procedures, usually provided for a specific quadrant, is limited to one surgical-type procedure, per quadrant every 36 months). Reimbursement for periodontal scaling and root planing procedures per specific quadrant is limited to one procedure in a 12-month interval.
- Periodontal surgical procedures, usually provided for specific quadrants, are subject to a reduced reimbursement when the number of diseased teeth in a quadrant are less than four. Additional reduction in benefits may apply, when multiple types of procedures are provided in the same quadrant, at the same appointment.
- Restorative procedures, including fillings, inlays, onlays, and crowns (the replacement of a crown is covered only after a five-year period measured from the date on which the crown was previously placed).
- Emergency palliative treatment.
- Routine extractions of teeth.

- Endodontic services, such as pulpotomy and root canal therapy.
- Space maintainers (other than for orthodontic treatment).
- Oral surgical procedures considered dental in nature — such as, but not limited to: surgical extractions, treatment of fractures, removal of lesions of the mouth, and alveolectomy.
- Apicoectomy.
- General anesthesia (including conscious sedation coverage) when medically necessary and in connection with covered oral and periodontal surgical procedures.

SERVICES THAT ARE NOT ELIGIBLE FOR REIMBURSEMENT

- Any orthodontic service.
- Gold restorations other than crowns, inlays, and onlays.
- Any service or item not reasonably necessary for the dental care of the patient.
- Endosteal, subperiosteal, and transosteal tooth implants.
- Protective devices such as athletic mouth guards.
- Plaque control.
- Myofunctional therapy.
- A charge in connection with appliances, restorations, or procedures needed to alter vertical dimensions or restore occlusion, or for the purpose of splinting or correcting attrition, abrasion, or erosion.
- Crowns, inlays, or onlays if used in splinting procedures during periodontal treatment.
- Charges for sterilization or asepsis.
- A service for cosmetic purposes.
- Any charge for a supply that is normally for home use such as toothpaste, toothbrushes, water-pick, or mouthwash.
- A dental examination when required as a condition of employment by an employer, a government agency, or the terms of a labor agreement.
- Charges for services not reasonably necessary to produce a professionally acceptable result.
- A service or supply due to a war or any act of war.
- A service not furnished by a dentist or physician licensed to provide the dental service, except for a service performed by a licensed dental hygienist under the direction of a dentist.
- A service rendered by a provider that is beyond the scope of the provider's license.
- A charge made by a dentist for a failure of the patient to keep an appointment.
- A charge for the completion of any claim forms.

- A charge in connection with any procedure started before the patient was eligible for reimbursement in this plan; except that a procedure will not have been considered to have started with an oral prophylaxis or a diagnostic procedure.
- Any service or supply which is furnished or made available to a patient or financed by federal, State, or local government, including Medicare or a like plan, Workers' Compensation law or a similar law, any automobile no-fault law, or any other plan or law under which the patient is or could be covered, whether or not the patient makes any claim or receives compensation under it.
- Any charge incurred after the patient is no longer covered, except in the case of an extension of coverage (see page 20).
- Any charge for a service that is more than the reasonable and customary allowance (see page 5).
- Any charge for a service rendered by a member of the patient's immediate family (including you, your spouse/partner, your child, brother, sister, or parent of you or your spouse/partner).
- Any service or supply other than those specifically covered under this program.

COORDINATION OF BENEFITS WITH OTHER INSURANCE PLANS

There is no coordination of benefits between SHBP two dental plans because no member is eligible for coverage under more than one dental plan. You and your spouse or eligible partner may be covered under a dental plan as an employee/retiree or as a dependent but not as both.

If you and your dependents are also covered for dental expenses by other plans, certain rules apply that determine which plan provides the primary coverage and how much each plan will reimburse you. The purpose of these rules is to prevent a combined reimbursement from both plans that exceeds the expenses that you actually incur. Although there may be special cases not described here, the basic determination of which plan provides primary coverage is as follows:

- The retiree's primary dental coverage is provided by the Retiree Dental Expense Plan. If the retiree is also employed, and has dental coverage through another employer other than the State, then the dental coverage provided by the employer is primary to the Retiree Dental Expense Plan.
- If your spouse/partner is enrolled as your dependent and is also covered by a dental plan through his or her employer, your spouse/partner's primary coverage and any dependents also covered by your spouse/partner is through the dental plan offered by his or her employer.
- Coverage through a parent's active employment is primary over coverage through a retiree for children. If both parents are retired see the birthday rule below.
- If your children are enrolled as dependents in your plan and your spouse/partner's plan, their primary coverage is provided by the dental plan of the parent whose birthday falls earlier in the year. If your spouse/partner's plan does not follow this rule, then the rule in the other plan will determine the order of benefits.
- In the case of a separation or divorce, the primary coverage for a child is provided in this order: by the plan of the parent who is legally responsible for the dental expenses of the child; by the plan of the parent with custody of the child; by the plan of the spouse/partner of the parent with custody of the child; or by the plan of the non-custodial parent.

ENROLLING IN THE RETIREE DENTAL EXPENSE PLAN

RETIREE ENROLLMENT

How to Enroll

For new retirees or individuals becoming eligible for Retired Group SHBP or SEHBP coverage, the Division of Pensions and Benefits will include dental enrollment materials at the same time it sends the Retired Group health plan offering letter which is generally within 30 to 60 days of retirement or eligibility for retiree group plan coverage.

If you are covered under a group dental plan as a dependent or as an employee through other employment when first offered enrollment, you may opt to waive this opportunity to enroll in the Retiree Dental Expense Plan and elect to enroll at a future date when your other coverage has ended. You must contact the Division of Pensions and Benefits within 60 days of the loss of the other dental coverage and request enrollment materials. Proof of loss of coverage must be submitted with the enrollment application. Acceptable documentation includes a letter from the employer providing date of termination of coverage, a *HIPAA Certification of Coverage* form, etc.

Enrolling Dependents

You may enroll your eligible dependents when you enroll.

If you have a new dependent, you may enroll the dependent effective the date you acquired the dependent provided you submit a completed *Retired Change of Status Application* within 60 days of the dependent's eligibility.

If you do not enroll an eligible dependent because of other coverage and that coverage is lost, you can enroll that dependent providing you submit a completed *Retired Change of Status Application* within 60 days of the event. A copy of your spouse/partner's and/or dependent's *HIPAA Certification of Coverage* form must be submitted with the enrollment application. Coverage for that dependent will be effective the date of the qualifying event (date of loss of other coverage).

If you do not enroll a dependent within 60 days of eligibility, there will be at least a 2-month waiting period from the date a completed *Retired Change of Status Application* is received until the dependent is covered. Coverage for that dependent will be effective the first day of the month following a minimum 60-day waiting period. A dependent added in this manner may be added to a retiree's contract only once.

Levels of Coverage

There are four levels of coverage offered through the plan:

- **Single:** covers the retiree only.
- **Member (Retiree) and Spouse/Partner:** covers the retiree and his or her spouse, civil union partner, or eligible same-sex domestic partner*.
- **Parent and Child(ren):** covers the retiree and all enrolled eligible children.
- **Family:** covers retiree, spouse/partner*, and all enrolled eligible children.

*See page 3 for limitations on the eligibility of domestic partners.

Dual Dental Plan Enrollment is Prohibited

You and your spouse/partner may be covered under a dental plan as an SHBP or SEHBP eligible employee/retiree or as a dependent but not as both. For example, if two retirees are married to each other and both eligible for SHBP and/or SEHBP enrollment, each may elect to enroll for single coverage only, or one retiree may enroll the other as a dependent if the other person waives dental plan coverage. Furthermore, two employees/retirees cannot each enroll the same children as dependents under their respective dental coverage.

Retiree Dental Expense Plan Premiums

Most retirees will pay the full cost of the Retiree Dental Expense Plan. The State does not pay for the cost of coverage, however, under certain circumstances, a local public employer that participates in the SHBP or SEHBP may elect to pay for or share the cost of coverage for its retirees (Chapter 48, P.L. 1999, below).

Premium payments are deducted from your monthly pension check. If your monthly pension check amount is not sufficient to cover the full premium, you will be billed monthly in advance of the coverage period.

You will also be billed directly for coverage if you receive a pension not paid by the Division of Pensions and Benefits, i.e., the Alternate Benefit Program (ABP).

Chapter 48, P.L. 1999 — Although the Retiree Dental Expense Plan is primarily available on a retiree-pay-all basis, local public employers that participate in the SHBP or SEHBP may contribute to the cost of retiree coverage as permitted by Chapter 48, P.L. 1999. This allows some local employers to pay all or a portion of the premium cost of the Plan for eligible retirees as a result of collective negotiation agreements. To do this, an eligible employer must file a Chapter 48 resolution pertaining to the Retiree Dental Expense Plan with the Health Benefits Bureau of the Division of Pensions and Benefits. These provisions would not apply to any local retiree who receives retiree health coverage at State (as opposed to local employer) expense.

WHEN COVERAGE BEGINS

Coverage under the Retiree Dental Expense Plan will become effective the same date as your Retired Group health plan coverage providing the Division of Pensions and Benefits is in receipt of the completed *Retired Coverage Enrollment Application* and any other required documentation.

- The effective date of coverage for a retiree (and eligible dependents) who was covered for health coverage as an active employee in the SHBP or SEHBP is approximately one month after the date of retirement, and generally coincides with the date that coverage as an active employee is terminated.
- The effective date of coverage for a new retiree (and eligible dependents) who was not covered as an active employee in the SHBP or SEHBP is the date of retirement.
- The effective date of coverage for TPAF or PERS members who retire from a board of education, vocational/technical school, or special services commission; participate in their employer's health plan (not SEHBP); and enroll in the SEHBP Retired Group when they enroll in Medicare will be the date that their Medicare Parts A and B are effective.
- The effective date of coverage for a surviving spouse or partner and eligible children is the date the coverage terminates as a dependent due to the death of the retiree.

When Dependent Coverage Begins

Upon receipt and acceptance of a completed *Retired Coverage Enrollment Application* and any required documentation, dependent coverage under the Retiree Dental Expense Plan will begin on:

- The date retiree coverage begins, provided that the retiree enrolls the dependent(s) when first eligible for enrollment; or
- The date of a change in family status involving a **marriage, civil union, eligible domestic partnership, birth, adoption, or guardianship** provided a completed *Retired Change of Status Application* is submitted within 60 days of the event; or
- The first of the month following a minimum 2-month waiting period if an application to add eligible dependents is not received within 60 days of a change of family status qualifying event (marriage, civil union, eligible domestic partnership, birth, adoption or guardianship).
- The first of the month following receipt of the application if you add an eligible dependent within 60 days of the loss of the dependent's other employer group dental coverage. Proof of the dependent's former coverage must accompany the application.

End of Coverage

Your coverage under the Retiree Dental Expense Plan terminates if:

- You formally request termination in writing, or by completing a *Retired Change of Status Application*;
- Your retirement is canceled;
- Your pension allowance is suspended;
- You do not pay your required premiums;
- Your former employer withdraws from the SHBP and/or SEHBP (this may not apply to certain retirees of education, police, and fire employers);
- Your Medicare coverage ends;
- You die (see “Survivor Coverage” below);
- The SHBP and/or SEHBP is discontinued; or
- You become ineligible for Retired Group medical coverage through the SHBP or SEHBP.

Coverage for your **dependents** will end if:

- Your coverage ceases for any of the reasons listed above;
- You die (see “Survivor Coverage” below);
- Your dependent is no longer eligible for coverage (divorce of a spouse; dissolution of a civil union or same-sex domestic partnership; children turn age 26 unless the dependent child qualifies for continuance of coverage due to disability — see page 4);
- Your enrolled dependent enters the Armed Forces; or
- Your dependent becomes enrolled on their own through the SHBP or SEHBP in a dental plan as a subscriber.

In general, once Retiree Dental Expense Plan coverage is terminated it will not be reinstated.

Survivor Coverage

If you, the retired member, predecease your covered dependents, your surviving dependents may be eligible for continued coverage in the Retiree Dental Expense Plan. Surviving dependents are generally notified of their rights to continued coverage at the time the Division of Pensions and Benefits is notified of the death of the retiree; however, they may contact the Divisions' Office of Client Services for enrollment forms or for more information. It is imperative that survivors notify the Division as soon as possible after your death because their **dependent coverage terminates the 1st of the month following the date of your death.**

EXTENSION OF COVERAGE PROVISIONS

Once coverage is terminated for you or any of your dependents, there is no eligibility for continuation of the Retiree Dental Expense Plan under the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

There is also no conversion to an individual policy authorized under this plan.

If Eligibility Ends While Undergoing Treatment

If your coverage is terminated due to your **voluntary termination** from the plan or **failure to pay** the required premium, there is no extension of ongoing treatment for you or your dependents.

If you die, and your dependent does not elect to continue the Retiree Dental Expense Plan coverage under their own account and is undergoing treatment, your dependent's coverage will be extended to cover the following procedures for up to 30 days following the end of their coverage:

- Production of an appliance or modification of an appliance for which the impression was taken while the person was covered.
- Preparation of a crown or restoration for which a tooth was prepared while the person was covered.
- Root canal therapy for which the pulp chamber was opened while the person is covered.

For Children Over the Age of 26 with Disabilities

In certain circumstances, coverage can be continued for a dependent child over the age of 26. See page 4 for more information about extending coverage for children with disabilities.

Please Note: Extended coverage provisions under Chapter 375, P.L. 2005, for over age children until age 31 do not apply to the Retiree Dental Expense Plan.

APPENDIX I

CLAIM APPEAL PROCEDURES

You or your authorized representative may appeal and request that the dental 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 dental nature. Administrative appeals might question eligibility or plan benefit decisions such as whether a particular service is covered or paid appropriately. Dental appeals refer to the determination of dental need, appropriateness of treatment, or experimental and/or investigational procedures.

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

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

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

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

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

Notification of all Commission decisions will be made in writing to the member. If the Commission approves the member's appeal, the decision is binding upon the dental 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 dental testimony, you will be responsible for any fees or costs incurred.

HIPAA PRIVACY

The Retiree Dental Expense Plan makes every effort to safeguard the dental information of its members and complies with the privacy provisions of the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA requires health plans to maintain the privacy of any personal information relating to its members' physical or mental health. See Appendix III (on page 25) for the SHBP/SEHBP's *Notice of Privacy Practices*.

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.

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.

APPENDIX II

GLOSSARY

Alveolectomy — Surgical excision of a portion of the dentoalveolar process, for recontouring the tooth socket ridge at the time of tooth removal in preparation for a dental prosthesis (denture).

Amalgam — An alloy used in dental restoration.

Apicoectomy — Surgical removal of a dental root apex. Root resection.

Bitewing X-Ray — X-rays taken with the film holder held between the teeth and the film parallel to the teeth.

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 supportive 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).

Coinsurance — The percentage of the eligible charge that the retiree/member must pay.

Crown — That part of a tooth that is covered with enamel or an artificial substitute for that part.

Deductible — The first eligible expense, or portion thereof, incurred within each calendar year that the member is required to pay before reimbursement for eligible expenses begins.

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).

Endodontics — Concerned with the biology and pathology of the dental pulp and surrounding tissues. Root canal treatment.

Inlay — A cast metallic or ceramic filling for a dental cavity.

Member — With respect to the Retiree Dental Expense Plan, retirees eligible to enroll in the State Health Benefits Program and their dependents including a spouse, civil union partner, or eligible same-sex domestic partner.

Member Identification Card — A wallet-sized, plastic card issued by Aetna that identifies the retiree/dependent named thereon as a plan member.

Onlay — A type of metal restoration that overlays the tooth to provide additional strength to that tooth.

Palliative Treatment — Alleviation of symptoms without curing the underlying disease.

Periodontics — Concerned with the treatment of abnormal conditions and diseases of the tissues that surround and support the teeth.

Prophylaxis — A series of procedures whereby calculus (calcified deposits), stain, and other accretions are removed from the clinical crowns of the teeth and the enameled surfaces are polished.

Prosthodontics — The science and art of providing suitable substitutes for crowns of teeth, or for replacing lost or missing teeth.

Public Employer — A federal, state, county, or municipal government, authority, or agency; a local board of education; or a state or county university or college.

Resin — A material used in dental restoration.

Scaling and Root Planing — The removal of subgingival calcified deposits around the teeth and the cleaning of the gingival pocket.

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.

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 originally established by statute 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 and its plans. The State Health Benefit Program Act is found in the N.J.S.A. 52:17.25 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

APPENDIX III

NOTICE OF PRIVACY PRACTICES TO ENROLLEES

State Health Benefits Program School Employees' Health Benefits Program

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Protected Health Information

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

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

Uses and Disclosures of PHI

The Program is permitted to use and to disclose PHI in order for our members to obtain payment for health care services and to conduct the administrative activities needed to run the Program without specific member authorization. Under limited circumstances, we may be able to provide PHI for the health care operations of providers and health plans. Specific examples of the ways in which PHI may be used and disclosed are provided below. This list is illustrative only and not every use and disclosure in a category is listed.

- The Program may disclose PHI to a doctor or a hospital to assist them in providing a member with treatment.
- The Program may use and disclose member PHI so that our Business Associates may pay claims from doctors, hospitals, and other providers.

- The Program receives PHI from employers, including the member's name, address, Social Security number, and birth date. This enrollment information is provided to our Business Associates so that they may provide coverage for health care benefits to eligible members.
- The Program and/or our Business Associates may use and disclose PHI to investigate a complaint or process an appeal by a member.
- The Program may provide PHI to a provider, a health care facility, or a health plan that is not our Business Associate that contacts us with questions regarding the member's health care coverage.
- The Program may use PHI to bill the member for the appropriate premiums and reconcile billings we receive from our Business Associates.
- The Program may use and disclose PHI for fraud and abuse detection.
- The Program may allow use of PHI by our Business Associates to identify and contact our members for activities relating to improving health or reducing health care costs, such as information about disease management programs or about health-related benefits and services or about treatment alternatives that may be of interest to them.
- In the event that a member is involved in a lawsuit or other judicial proceeding, the Program may use and disclose PHI in response to a court or administrative order as provided by law.
- The Program may use or disclose PHI to help evaluate the performance of our health plans. Any such disclosure would include restrictions for any other use of the information other than for the intended purpose.
- The Program may use PHI in order to conduct an analysis of our claims data. This information may be shared with internal departments such as auditing or it may be shared with our Business Associates, such as our actuaries.

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

When using or disclosing PHI, the Program will make every reasonable effort to limit the use or disclosure of that information to the minimum extent necessary to accomplish the intended purpose. The Program maintains physical, technical and procedural safeguards that comply with federal law regarding PHI.

Member Rights

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

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

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

We cannot amend demographic information, treatment records or any other information created by others. If members would like to amend any of their demographic information, please contact your personnel office. To amend treatment records, a member must contact the treating physician, facility, or other provider that created and/or maintains these records.

The Program may deny the member's request if: 1) we did not create the information requested on the amendment; 2) the information is not part of the designated record set maintained by the Program; 3) the member does not have access rights to the information; or 4) we believe the information is accurate and complete. If we deny the member's request, we will provide a written explanation for the denial and the member's rights regarding the denial.

Right to an Accounting of Disclosures: Members have the right to receive an accounting of the instances in which the Program or our Business Associates have disclosed member PHI. The accounting will review disclosures made over the past six years or back to April 14, 2003, whichever period is shorter. We will provide the member with the date on which we made a disclosure, the name of the person or entity to whom we disclosed the PHI, a description of the information we disclosed, the reason for the disclosure, and certain other information. Certain disclosures are exempted from this requirement (e.g., those made for treatment, payment or health benefits operation purposes or made in accordance with an authorization) and will not appear on the accounting.

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

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

To request changes to confidential communications, the member must make their request in writing, and must clearly state that the information could endanger them if it is not communicated in confidence as they requested.

Questions and Complaints

If you have questions or concerns, please contact the Program using the information listed at the end of this Notice. (Local county, municipal, and Board of Education employees should contact the HIPAA Privacy Officer for their employer.)

If members think the Program may have violated their privacy rights, or they disagree with a decision made about access to their PHI, in response to a request made to amend or restrict the use or disclosure of their information, or to have the Program communicate with them in confidence by alternative means or at an alternative location, they must submit their complaint in writing. To obtain a form for submitting a complaint, use the contact information found at the end of this Notice.

Members also may submit a written complaint to the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201.

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

Contact Office: The Division of Pensions and Benefits
HIPAA Privacy Officer

Address: Division of Pensions and Benefits
Bureau of Policy and Planning
PO Box 295
Trenton, NJ 08625-0295

Fax: (609) 341-3410

E-mail: hipaaform@treas.state.nj.us

HEALTH BENEFITS CONTACT INFORMATION

ADDRESSES

Our Mailing Address isDivision of Pensions and Benefits
Health Benefits Bureau
PO Box 299
Trenton, NJ 08625-0299

Our Internet Address iswww.state.nj.us/treasury/pensions/health-benefits.shtml

Our E-mail Address ispensions.nj@treas.state.nj.us

TELEPHONE NUMBERS

Division of Pensions and Benefits:

Office of Client Services(609) 292-7524

TDD Phone (Hearing Impaired)(609) 292-7718

Aetna Dental1-877-238-6200

State Employee Advisory Service (EAS)(609) 292-8543

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

New Jersey State Police

Employee Advisory Program (EAP)(856) 234-5652

.....(908) 231-1077

.....(609) 633-3718

.....1-800-FOR-NJSP

University of Medicine and Dentistry of New Jersey (EAP).....(973) 972-5429

New Jersey Department of Banking and Insurance

Individual Health Coverage Program Board1-800-838-0935

Consumer Assistance for Health Insurance(609) 292-5316
(Press 2)

New Jersey Department of Human Services

Pharmaceutical Assistance
to the Aged and Disabled (PAAD)1-800-792-9745

New Jersey Department of Health and Senior Services

Division on Senior Affairs1-800-792-8820

Insurance Counseling1-800-792-8820

Independent Health Care Appeals Program(609) 633-0660

Centers for Medicare and Medicaid Services

New Jersey Medicare - Part A and Part B1-800-Medicare

HEALTH BENEFITS PUBLICATIONS

The publications and fact sheets available from the Division of Pensions and Benefits provide information on a variety of subjects. Fact sheets, handbooks, applications, and other publications are available for viewing or downloading over the Internet at:

www.state.nj.us/treasury/pensions

General Publications

SHBP/SEHBP Summary Program Description

Plan Comparison Summary for State Employees

Plan Comparison Summary for Local Government Employees

Plan Comparison Summary for Local Education Employees

Plan Comparison Summary for All Retirees

Health Benefit Fact Sheets

Fact Sheet #11, Enrolling in the Health Benefits Coverage When you Retire

Fact Sheet #23, Health Benefits and Medicare Parts A & B for Retirees

Fact Sheet #25, Employer Responsibilities under COBRA

Fact Sheet #26, Health Benefits Options upon Termination of Employment

Fact Sheet #30, The Continuation of Health Benefits Coverage under COBRA

Fact Sheet #37, Employee Dental Plans

Fact Sheet #47, Retired Health Benefits Coverage under Chapter 330 - PFRS & LEO

Fact Sheet #51, Continuing Health Benefits Coverage for Over Age Children with Disabilities

Fact Sheet #60, Voluntary Furlough Program

Fact Sheet #66, Health Benefits Coverage for Part-Time Employees

Fact Sheet #69, SHBP Coverage for State Intermittent Employees

Fact Sheet #71, Benefits under the Domestic Partnership Act

Fact Sheet #73, Retiree Dental Expense Plan

Fact Sheet #74, Health Benefits Coverage of Children until Age 31 under Chapter 375, P.L. 2007

Fact Sheet #75, Civil Unions

Health Plan Member Handbooks

NJ DIRECT Member Handbook

Aetna HMO Member Handbook

CIGNA HealthCare Member Handbook

Employee Prescription Drug Plan Member Handbook

Employee Dental Plans Member Handbook

Retiree Dental Expense Plan Member Handbook

NOTES



HD-0714-1010