

STATE HEALTH BENEFITS PROGRAM

PLAN COMPARISON SUMMARY

FOR LOCAL GOVERNMENT EMPLOYEES

EFFECTIVE JANUARY 1, 2009

The *Plan Comparison Summary* provides a way for employees to compare the benefits of the medical plans offered by the State Health Benefits Program (SHBP). If you are new to the SHBP, or a member who is considering a different medical plan, the *Plan Comparison Summary* is a useful resource for selecting a plan. For members who want to know more about their current plan, the *Plan Comparison Summary* is a quick reference to the services offered.

The following sections summarize plan designs and general policies of the SHBP. Inside, the comparison chart summarizes the benefits each plan provides for specified services.

MEDICAL PLANS

Local Government employees are offered the choice of a Preferred Provider Organization, with two options known as **NJ DIRECT10** and **NJ DIRECT15** (administered by Horizon Blue Cross Blue Shield of New Jersey), and two HMO plans — **Aetna HMO** and **CIGNA HealthCare**.

All of the medical plans are managed care plans, meaning that they provide coverage for preventive care such as annual checkups and screening tests, well-baby visits, and immunizations, in the hope of avoiding serious illness and more costly treatment.

NJ DIRECT10 and **NJ DIRECT15** provide both *in-network* and *out-of-network* medical care. Under NJ DIRECT10 and NJ DIRECT15, members may see any physician, nationwide, and do not need to select a Primary Care Physician (PCP) for in-network care.

In-network care is provided through a network of providers that includes internists, general practitioners, specialists, pediatricians, and hospitals.

No referrals are needed for visits to a specialist. If the physician participates in the Horizon BCBSNJ Managed Care Network, the member only pays the appropriate copayment¹. Members living outside of New Jersey can utilize physicians participating in the national Blue Cross Blue Shield Network. In-network hospital admissions are also covered in full².

If the physician *does not* participate in the Horizon BCBSNJ Managed Care Network or the national network, the services will be considered *out-of-network*. Contact your doctor to see if he or she participates in the Horizon BCBSNJ Managed Care or national network. To find current participating physicians contact Horizon BCBSNJ directly. Plan telephone numbers and Web site addresses are listed on the comparison charts.

Out-of-network benefits provide reimbursement for eligible services rendered for the treatment of illness and injury. Most out-of-network care is reimbursed at a percentage of “reasonable and customary” allowances after a member’s annual deductible is met. Out-of-network hospital admissions are subject to a separate deductible.

NJ DIRECT10 and NJ DIRECT15 include annual maximum out-of-pocket amounts. This means that when a member’s, or family’s, out-of-pocket maximum is reached, covered benefits are paid at 100 percent of the allowance through the remainder of the calendar year².

Aetna HMO and **CIGNA HealthCare** have expanded networks that provide services nationwide. When you enroll in an HMO you must select a Primary Care Physician (PCP) from a group of participating providers contracted by the HMO.

(continued inside)

¹ Certain in-network covered benefits require 10% member coinsurance.

² Certain services may require pre-certification from Horizon BCBSNJ. Services that require a pre-certification, but are not pre-certified, will be paid at out-of-network benefit levels and will not count towards out-of-pocket maximums.

All services, except emergencies and as indicated on the enclosed comparison chart, are coordinated through your PCP. If you require the care of a specialist, your PCP will refer you to a specialist who participates in the HMO network. Electronic referrals are used by the HMOs and, therefore, no paperwork is required. Specialist services rendered without a valid referral, or by a provider who does not participate in the HMO (except for emergencies), will not be paid by the HMO.

HMOs have no deductibles (except for durable medical equipment) or claim forms to file, however, you are required to pay a copayment for visits to your PCP or a referred specialist. There are no out-of-network benefits, or out-of-pocket maximum amounts under an HMO plan.

If you are considering an HMO, contact your doctor's office to see if they participate in the HMO you have selected. To find current participating physicians contact the HMO directly. Plan telephone numbers and Web site addresses are listed on the comparison charts.

DEFINITIONS

A **copayment** is the fee paid by the member to the in-network physician at the time covered services are rendered.

Coinsurance is the portion of the eligible charge that is the member's responsibility for out-of-network and some in-network services (durable medical equipment and ambulance). When utilizing out-of-network providers, charges above the "reasonable and customary" allowance are the member's responsibility but are not considered "coinsurance" for the purposes of out-of-pocket maximums.

Pre-certification requires that the member (or the treating physician/facility) receive prior authorization from the medical plan to determine medical necessity before certain services are provided. Some examples of services that require pre-certification are inpatient admissions, reconstructive procedures, durable medical equipment purchases, specialty pharmaceuticals, hospice, and home health care. A detailed list is available from your medical plan.

DUAL HMO ENROLLMENT IS PROHIBITED

State statute specifically prohibits two employees/retirees who are both enrolled in the SHBP or School Employees' Health Benefits Program (SEHBP) and who are married to each other, civil union partners, or eligible domestic partners from enrolling under both of the SHBP/SEHBP HMO plans. One member may belong to an HMO as an employee or as a dependent but not as both.

For example, if two members are married to each other, each may enroll for single coverage under each of the HMOs, or one member can enroll the other as a dependent under an HMO if the other person enrolls in NJ DIRECT10 or NJ DIRECT15.

Furthermore, two members cannot both cover the same children as dependents under both of the HMO plans.

In cases of divorce, dissolution of a civil union or domestic partnership, or single parent coverage of dependents, there is no coordination of benefits under two HMO plans.

AUDIT OF DEPENDENT COVERAGE

Periodically, the Division of Pensions and Benefits performs an audit using a random sample of members to determine if dependents are eligible under plan provisions. Proof of dependency such as a marriage, civil union, or birth certificate is required. Coverage for ineligible dependents will be terminated. Failure to respond to the audit will result in the termination of dependents from coverage and may include financial restitution for claims paid.

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 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.

MORE INFORMATION

For more information about eligibility and enrollment, see the *NJ DIRECT*, *Aetna HMO* or *CIGNA HealthCare Member Handbooks* — available over the Internet from the Division of Pensions and Benefits at:

www.state.nj.us/treasury/pensions/shbp.htm

STATE HEALTH BENEFITS PROGRAM COMPARISON CHART FOR LOCAL GOVERNMENT EMPLOYEES

PLAN NAME TELEPHONE NUMBER and WEB SITE	#019 - AETNA HMO 1-877-STATE NJ (1-877-782-8365) www.aetna.com/statenj	#020 - CIGNA HEALTHCARE 1-800-564-7642 www.cigna.com/stateofnj	#050 - NJ DIRECT10 / #150 - NJ DIRECT15 1-800-414-SHBP (1-800-414-7427) www.horizonblue.com/shbp	
			IN-NETWORK ¹	OUT-OF-NETWORK ¹
SERVICE AREAS	Nationwide	Nationwide	Nationwide	Nationwide
PRIMARY AND PREVENTIVE CARE				
PHYSICIAN (OFFICE VISITS)	100% after \$10 copayment per visit	100% after \$10 copayment per visit	100% after \$10 / \$15 copayment per visit	80% / 70% after deductible; no coverage for wellness care
ANNUAL ROUTINE PHYSICAL EXAMS	100% after \$10 copayment per visit	100% after \$10 copayment per visit	100% after \$10 / \$15 copayment per visit	Not covered
ROUTINE CHILD AND WELL-BABY CARE	100% after \$10 copayment per visit	100% after \$10 copayment per visit	100% after \$10 / \$15 copayment per visit	Not covered
IMMUNIZATIONS (EXCEPT FOR TRAVEL AND/OR JOB RELATED)	100% after \$10 copayment per visit	100% after \$10 copayment per visit	100% after \$10 / \$15 copayment per visit	Not covered except for children under 12 months; 80% / 70% after deductible
ANNUAL ROUTINE GYNECOLOGICAL EXAMS	100% after \$10 copayment per visit (no referral needed if using network provider)	100% after \$10 copayment per visit (no referral needed if using network provider)	100% after \$10 / \$15 copayment per visit	80% / 70% after deductible
ANNUAL ROUTINE MAMMOGRAM (ONE ANNUAL MAMMOGRAM FOR WOMEN AGE 40 AND OVER)	100%; no copayment (no referral needed if using network provider)	100%; no copayment	100%; no copayment	80% / 70% after deductible
PROSTATE SCREENING (ONE ANNUAL PROSTATE SCREENING FOR MEN AGE 40 AND OVER)	100% after \$10 copayment per visit	100% after \$10 copayment per visit	100% after \$10 / \$15 copayment per visit	Not covered
ANNUAL ROUTINE EYE EXAMINATIONS	100% after \$10 copayment per visit (no referral needed if using network provider)	100% after \$10 copayment per visit (no referral needed if using network provider)	100% after \$10 / \$15 copayment per visit	Not covered
HEARING AIDS	Not covered	Not covered	Not covered	Not covered

¹ In-network copayment \$10 for NJ DIRECT10 and \$15 for NJ DIRECT15; out-of-network reimbursement 80% for NJ DIRECT10 and 70% for NJ DIRECT15. Benefits, excluding hospital expenses, are based on the Horizon BCBSNJ discounted provider network allowance or the “reasonable and customary” fee schedule based at the 90th percentile.

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			IN-NETWORK ¹	OUT-OF-NETWORK ¹
SPECIALTY AND OUTPATIENT CARE				
SPECIALIST OFFICE VISITS	100% after \$10 copayment per visit; PCP referral required	100% after \$10 copayment per visit; PCP referral required	100% after \$10 / \$15 copayment per visit	80% / 70% after deductible; no coverage for wellness care
ALLERGY TESTING	100% after \$10 copayment per visit	100% after \$10 copayment per visit	100% after \$10 / \$15 copayment per visit	80% / 70% after deductible
ALLERGY TREATMENT ROUTINE INJECTIONS	100% after \$10 copayment per visit	100% after \$10 copayment per visit	100% after \$10 / \$15 copayment per visit	80% / 70% after deductible
PRENATAL CARE/ MATERNITY CARE	\$10 copayment for first prenatal office visit then 100% covered. Beginning Right Maternity Program - a voluntary prenatal education program	\$10 copayment for first prenatal office visit then 100% covered. Healthy Babies - a voluntary prenatal education program	\$10 / \$15 copayment for first prenatal office visit then 100% covered. Precious Additions - a voluntary prenatal education program	80% / 70% after deductible
INFERTILITY SERVICES (MUST BE PRE-CERTIFIED)	Diagnosis covered after \$10 copayment; treatment covered with limitations after \$10 copayment	Diagnosis covered after \$10 copayment; treatment covered with limitations after \$10 copayment	Diagnosis covered after \$10 / \$15 copayment; treatment covered with limitations after \$10 / \$15 copayment	Diagnosis covered at 80% / 70% after deductible; treatment covered with limitations at 80% / 70% after deductible
OUTPATIENT FACILITY VISITS				
CHEMOTHERAPY	100%; no copayment	100%; no copayment	100%; no copayment	80% / 70% after deductible
RADIATION THERAPY	100%; no copayment	100%; no copayment	100%; no copayment	80% / 70% after deductible
INFUSION THERAPY	100% after \$10 copayment per visit	100% after \$10 copayment per visit	100% after \$10 / \$15 copayment per visit	80% / 70% after deductible
X-RAYS AND LAB TESTS (OUTPATIENT)	100%; no copayment	100%; no copayment	100%; no copayment	80% / 70% after deductible
OUTPATIENT THERAPY (SPEECH,² OCCUPATIONAL, PHYSICAL)	100%; after \$10 copayment per visit; limit of 60 visits per condition per calendar year	100%; after \$10 copayment per visit; limit of 60 visits per condition per calendar year	100% after \$10 / \$15 copayment per visit	80% / 70% after deductible

¹ In-network copayment \$10 for NJ DIRECT10 and \$15 for NJ DIRECT15; out-of-network reimbursement 80% for NJ DIRECT10 and 70% for NJ DIRECT15. Benefits, excluding hospital expenses, are based on the Horizon BCBSNJ discounted provider network allowance or the “reasonable and customary” fee schedule based at the 90th percentile.

² Speech therapy limited to: restoration after a loss or impairment of a demonstrated previous ability to speak; develop or improve speech after surgical correction of a birth defect.

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			IN-NETWORK ¹	OUT-OF-NETWORK ¹
SPECIALTY AND OUTPATIENT CARE				
OUTPATIENT CARDIAC REHABILITATION THERAPY	100% after \$10 copayment per visit	100% after \$10 copayment per visit	100% after \$10 / \$15 copayment per visit	80% / 70% after deductible
CHIROPRACTIC CARE	100%; after \$10 copayment per visit; limit of 20 visits per calendar year; PCP referral required	100%; after \$10 copayment per visit; limit of 20 visits per calendar year	100% after \$10 / \$15 copayment per visit; limit of 30 visits per calendar year; combined in-network and out-of-network	80% / 70% after deductible for up to 30 visits per calendar year combined in-network and out-of-network
HOME HEALTH CARE	Services and supplies covered at 100% with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered	Services and supplies covered at 100% with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered	Services and supplies covered at 100% with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered	Services and supplies covered at 80% / 70% after deductible with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered
HOSPICE CARE (OUTPATIENT)	100%; no copayment	100%; no copayment	100%; no copayment	80% / 70% after deductible
DURABLE MEDICAL EQUIPMENT (DME)	\$100 deductible; then 100% for rest of calendar year	\$100 deductible; then 100% for rest of calendar year	90%; no copayment	80% / 70% after deductible
PROSTHETIC DEVICES (MUST BE APPROVED IN ADVANCE)	\$100 deductible; then 100% for rest of calendar year; combined deductible with Durable Medical Equipment	\$100 deductible; then 100% for rest of calendar year; combined deductible with Durable Medical Equipment	90%; no copayment	80% / 70% after deductible
INPATIENT SERVICES				
HOSPITAL (ROOM AND BOARD AND OTHER INPATIENT SERVICES)	100%; no copayment	100%; no copayment	100%; no copayment	80% / 70% after separate \$200 deductible per hospital stay
SKILLED NURSING FACILITIES	100%; no copayment; for up to 120 days per calendar year	100%; no copayment; for up to 120 days per calendar year	100%; no copayment; for up to 120 days per calendar year; combined in-network and out-of-network	80% / 70% after deductible; for up to 60 days per calendar year; combined in-network and out-of-network
HOSPICE FACILITY	100%; no copayment	100%; no copayment	100%; no copayment	80% / 70% after deductible
INPATIENT VISITS	100%; no copayment	100%; no copayment	100%; no copayment	80% / 70% after deductible

¹ In-network copayment \$10 for NJ DIRECT10 and \$15 for NJ DIRECT15; out-of-network reimbursement 80% for NJ DIRECT10 and 70% for NJ DIRECT15. Benefits, excluding hospital expenses, are based on the Horizon BCBSNJ discounted provider network allowance or the “reasonable and customary” fee schedule based at the 90th percentile.

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			IN-NETWORK ¹	OUT-OF-NETWORK ¹
SURGERY AND ANESTHESIA				
INPATIENT SURGERY	100%; no copayment	100%; no copayment	100%; no copayment	80% / 70% after deductible
OUTPATIENT SURGERY	100%; no copayment	100%; no copayment	100%; no copayment	80% / 70% after deductible
MENTAL HEALTH				
INPATIENT TREATMENT³	100%; no copayment; up to 35 days per calendar year	100%; no copayment; up to 35 days per calendar year	100%; no copayment; up to 25 days per calendar year; balance at 90% up to annual and/or lifetime maximums	50 days per calendar year at 50% after deductible up to annual and/or lifetime maximums
OUTPATIENT TREATMENT³	100% after \$10 copayment per visit; up to 30 visits per calendar year	100% after \$10 copayment per visit; up to 30 visits per calendar year	90% up to annual and/or lifetime maximums	80% / 70% after deductible up to annual and/or lifetime maximums
ALCOHOL AND DRUG ABUSE				
INPATIENT TREATMENT	100%; no copayment; up to 28 days per occurrence per calendar year	100%; no copayment; up to 28 days per occurrence per calendar year	Same as any other illness	Same as any other illness
INPATIENT DETOXIFICATION	100%; no copayment	100%; no copayment	Same as any other illness	Same as any other illness
OUTPATIENT TREATMENT	100%; no copayment; up to 60 visits per calendar year	100%; no copayment; up to 60 visits per calendar year	100%; no copayment; no visit limit	80% / 70% after deductible
INPATIENT REHABILITATION	100%; no copayment; up to 28 days per occurrence per calendar year	100%; no copayment; up to 28 days per occurrence per calendar year	Same as any other illness	Same as any other illness
OUTPATIENT DETOXIFICATION	100%; no copayment	100%; no copayment	Same as any other illness	Same as any other illness

¹ In-network copayment \$10 for NJ DIRECT10 and \$15 for NJ DIRECT15; out-of-network reimbursement 80% for NJ DIRECT10 and 70% for NJ DIRECT15. Benefits, excluding hospital expenses, are based on the Horizon BCBSNJ discounted provider network allowance or the "reasonable and customary" fee schedule based at the 90th percentile.

³ Biologically-based mental health conditions are treated like any other illness and not subject to annual or lifetime mental health dollar maximums or separate mental health visit limits.

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			IN-NETWORK ¹	OUT-OF-NETWORK ¹
EMERGENCY CARE				
HOSPITAL EMERGENCY ROOM (COPAYMENT WAIVED IF ADMITTED)	100% after \$35 copayment	100% after \$35 copayment	100% after \$25 / \$50 ⁴ copayment	100% after \$25 / \$50 ⁴ copayment
AMBULANCE (FOR EMERGENCY TRANSPORTATION ONLY)	100%; no copayment	100%; no copayment	90%; no copayment	80% / 70% after deductible
VOLUNTARY PROGRAMS				
DISEASE MANAGEMENT PROGRAMS⁵	Asthma, Chronic Heart Failure, Chronic Hepatitis, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Chron's Disease, Coronary Artery Disease, Diabetes, Gastro Esophageal Reflux, Inflammatory Bowel Disease, Low Back Pain, and Weight Management	Asthma, Chronic Obstructive Pulmonary Disease, Diabetes, Heart Disease, Hepatitis C, Inflammatory Bowel Disease, Low Back Pain, Osteoarthritis, Osteoporosis, and Weight Complications	Asthma, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Diabetes, Heart Failure, Hepatitis C, Obesity, and Multiple Sclerosis	Asthma, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Diabetes, Heart Failure, Hepatitis C, Obesity, and Multiple Sclerosis
PLAN DEDUCTIBLES, OUT-OF-POCKET MAXIMUMS, AND ANNUAL/LIFETIME BENEFIT MAXIMUMS				
DEDUCTIBLES (INDIVIDUAL)	None	None	None	\$100 per calendar year; \$200 per hospital admission
DEDUCTIBLES (FAMILY MAXIMUM)	None	None	None	\$250 per family, per calendar year; \$200 per hospital admission
MAXIMUM OUT-OF-POCKET (INDIVIDUAL)	No maximum	No maximum	\$400 per calendar year (coinsurance and copayments) ⁶	\$2,000 per calendar year (coinsurance only)
MAXIMUM OUT-OF-POCKET (FAMILY)	No maximum	No maximum	\$1,000 per calendar year (coinsurance and copayments) ⁶	\$5,000 per calendar year (coinsurance only)
MAXIMUM PLAN COVERED EXPENSES ANNUAL/LIFETIME	Unlimited	Unlimited	Unlimited ⁷	\$1,000,000 lifetime ⁷

¹ In-network copayment \$10 for NJ DIRECT10 and \$15 for NJ DIRECT15; out-of-network reimbursement 80% for NJ DIRECT10 and 70% for NJ DIRECT15. Benefits, excluding hospital expenses, are based on the Horizon's discounted provider network allowance or the "reasonable and customary" fee schedule based at the 90th percentile.

⁴ NJ DIRECT10 emergency room copayment is \$25; NJ DIRECT15 emergency room copayment is \$50.

⁵ Most disease management programs provide educational materials, and in some cases, individualized case management for members with an emphasis on health education and behavior modification.

⁶ Under NJ DIRECT15, only coinsurance goes toward in-network out-of-pocket expenses.

⁷ Mental Health Maximums: \$15,000 annual; \$50,000 lifetime. Up to \$2,000 restoration feature each year with a lifetime maximum of \$50,000. Biologically-based mental health conditions are treated like any other illness and not subject to annual or lifetime mental health dollar maximums or separate mental health visit limits.

PRESCRIPTION DRUG COVERAGE FOR LOCAL GOVERNMENT EMPLOYEES

Employers have the option of providing the **Employee Prescription Drug Plan**, or another drug plan, as a separate prescription drug benefit. If the employer provides a separate prescription drug plan to employees, the medical plan will not include any drug coverage.

If no separate prescription drug plan is provided, the medical plan will provide drug coverage as noted below.

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	IN-NETWORK		OUT-OF-NETWORK	
PRESCRIPTION DRUG ⁷ Benefits for employees without employer prescription drug plan	PHARMACY Copayment for 30-day supply		PHARMACY Copayment for 30-day supply	
	Generic	\$5	Generic	\$5
	Preferred brand	\$10	Preferred brand	\$10
	Other brands	\$20	Other brands	\$20
	MAIL ORDER Copayment for 90-day supply		MAIL ORDER Copayment for 90-day supply	
	Generic	\$5	Generic	\$5
	Preferred brand	\$15	Preferred brand	\$15
	Other brands	\$25	Other brands	\$25
		NJ DIRECT10 and NJ DIRECT15 90% reimbursement		NJ DIRECT10 - 80% after deductible NJ DIRECT15 - 70% after deductible

⁷Certain prescription drugs may require precertification prior to purchase. Please contact your plan for details.

DENTAL COVERAGE FOR LOCAL GOVERNMENT EMPLOYEES

Employers have the option to offer the **Employee Dental Plans**, or another dental plan, as a separate dental benefit.

If provided by your employer, the **Employee Dental Plans** offer two basic types of plan: the Dental Expense Plan, and a selection of Dental Plan Organizations (DPOs). For more information, see the *Employee Dental Plans Member Handbook* which is available from the Division of Pensions and Benefits on our Web site at:

www.state.nj.us/treasury/pensions/shbp.htm

If your employer offers another dental plan, contact your benefits administrator for plan information.

CONTINUED COVERAGE FOR CHILDREN AGE 23 THROUGH 31

Coverage for a dependent child ends on December 31 of the year in which the child turns age 23. When a covered child turns age 23, you will receive a COBRA notice outlining the right to purchase continued health coverage for up to 36 months. However, under the provisions of Chapter 375, P.L. 2005, a child who is under age 31, may be eligible for continued medical and prescription drug coverage at a lesser cost than COBRA. See Fact Sheet #74, *Health Benefits Coverage of Children Until Age 31*. Continued dental and vision coverage may be available under COBRA.

If a covered child is not capable of self-support when he or she reaches age 23 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuance of coverage. A *Continuance for Dependent with Disabilities* form and proof of the child's condition must be submitted no more than 31 days after the date that coverage would end. Since coverage ends on December 31 of the year the child turns 23, you usually have until January 31 to file the form. See Fact Sheet #51, *Continuing Health Benefits Coverage for Over Age Children with Disabilities*.

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(609) 292-7524 • TDD for the hearing impaired (609) 292-7718

URL: www.state.nj.us/treasury/pensions • E-mail: pensions.nj@treas.state.nj.us

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

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