

ENROLLING IN HEALTH BENEFITS

Active Employee 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 along with any required supporting documentation. 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 (see "Change of Coverage" for exceptions).

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. 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 enrollment application. See page 55 for more information about the documentation a member must provide when enrolling a new dependent for coverage.

Open Enrollment

An annual Open Enrollment period is held for all eligible State employees and local participating employees. Specific dates for the Open Enrollment period are announced in advance. Coverage changes made during the Open Enrollment period will be effective the first biweekly payroll period of the new plan year for State employees paid through the State's Centralized Payroll Unit, and January 1 of the following year for all other State and local employees. Completed applications must be returned to your human resources represen-

tative or payroll officer by the deadline indicated in the Open Enrollment announcement materials.

The annual Open Enrollment period is your opportunity to make changes to the coverage provided to you and your dependents. During the Open Enrollment period, you may:

- enroll in any of the plans offered for which you are eligible, if you have not previously enrolled;
- change to another eligible health plan;
- enroll in, or change dental plans (if eligible and enrolled in your previous dental plan for a minimum of 12 months);
- add eligible dependents you have not previously enrolled (including over age children eligible under Chapter 375, see page 7); and
- delete dependents (this can also be done at any time during the year).

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.

Waiver of Coverage

An employer other than the State participating in the SHBP or SEHBP may allow an employee who is covered as a dependent under a spouse's or partner's employer-provided health benefits coverage, to waive SHBP or SEHBP health benefits coverage and be reimbursed up to 25 percent of the amount saved by the employer, or \$5,000, whichever is less. Coverage may be resumed if the spouse's or partner's dependent coverage is no longer in effect. The decision of an employer to allow its employees to waive coverage and the amount of consideration to be paid are not subject to collective bargaining.

Change of Coverage

To change your coverage you should contact your benefits administrator or human resource representative. To change your coverage due to any of the circumstances listed below, **you must submit a completed Health Benefits Program Application and all required supporting documentation within 60 days of the event.** See page 55 for more information about the documentation a member must provide when enrolling a new dependent for coverage.

You are eligible to change your level of coverage within the same plan under the following circumstances:

- You marry and want to enroll your spouse and newly eligible children. **A photocopy of the marriage certificate, and/or birth certificates for any children, and all required supporting documentation must accompany the application;**
- You enter into a civil union or same-sex domestic partnership and want to enroll your eligible partner and newly eligible children. **A photocopy of the New Jersey Civil Union Certificate, Certificate of Domestic Partnership, and/or birth certificates for any children, and all required**

supporting documentation must accompany the application (may not apply to all employees, see page 6 for additional information about eligible same-sex domestic partners);

- You need to enroll a child. **A photocopy of legal documentation (birth certificate, adoption or guardianship papers, etc.)** must accompany the application (non-custodial parents, see page 55);
- You have a change in family status involving the loss of eligibility of a family member (divorce; dissolution of a civil union or same-sex domestic partnership; death);
- Your spouse's, civil union partner's, eligible same-sex domestic partner's, or eligible dependent's employment status changes resulting in a loss of health coverage. **A photocopy of your spouse/partner's and/or dependent's Certificate of Continued Coverage and required supporting documentation must accompany the application;**
- You are going on a leave of absence and cannot afford to pay for coverage. You can reduce your coverage, for example, from "Family" to "Parent and Child" coverage when you go on leave and increase it back to "Family" upon your return to work.

You are eligible to change your coverage to another plan under the following circumstance:

- You return from a leave of absence. If you elected not to continue benefits while on leave of absence, or you missed the open enrollment period, upon your return from leave you may elect to enroll in any plan for which you are eligible or at any coverage level as appropriate.

Effective Dates of Coverage

There is a waiting period of two months following your date of hire before your health benefits cov-

erage begins, provided you submit a completed Health Benefits Program Application and all required supporting documentation. Your enrolled dependent's coverage is effective the same date as yours, provided you have paid any required contribution.

Coverage for State biweekly employees begins on the first day of your fifth payroll period. The exact date of your coverage will be determined by the State's centralized payroll date schedule. Contact your benefits administrator or human resources representative if you need to know the exact date of coverage.

For all other employees, your coverage begins on the first day following two months of employment. For example, if you start work on September 15, your coverage will be effective November 15. The following exceptions apply to this effective date of coverage:

- If you have at least two months of service on the date your employer joins the SHBP or SEHBP, your coverage starts on the date your employer enters the program;
- If you have an annual contract, are paid on a 10-month basis, and begin work at the beginning of the contract year, your coverage will begin on September 1;
- If you were enrolled in the SHBP or SEHBP with your previous employer and your coverage is still in effect on the day you begin work with your current employer (COBRA coverage excluded), your coverage begins immediately so you have no break in coverage (see "Transfer of Employment").

Coverage changes involving the addition of dependents are effective retroactive to the date of the event (marriage, civil union, birth, adoption, etc.) provided that the application and all required supporting documentation is filed within 60 days of the event.

Deletion of dependents is effective on a timely or prospective basis, depending upon receipt of the applica-

tion by the Health Benefits Bureau, except for the following:

- Dependent children are automatically terminated as of the end of the year they attain age 26 and do not require the completion of an application to decrease coverage; or
- Children covered under the provisions of Chapter 375, are terminated from coverage on the first of the month following the event that no longer makes them eligible.

Transfer of Employment

If you transfer from one participating employer to another, including transfer within State employment, coverage may be continued without any waiting period provided that you:

- are still enrolled by the SHBP or SEHBP (COBRA, State part-time, and part-time faculty coverage excluded) when you begin in your new position; or
- transfer from one participating employer to another; **and**
- file a new Health Benefits Program Application listing the former employer in the appropriate section of the application.

Leaves of Absence

Leaves of absence encompass all approved leaves with or without pay. These include:

- Approved leave of absence for illness;
- Approved leave of absence other than illness;
- Family Leave Act (federal and State);
- Furlough;
- Workers' Compensation;
- Suspension (COBRA continuation only).

NOTE
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While you are on leave of absence, you can choose to reduce your level of coverage for the duration of your leave and increase it again when you return from leave. For example, you can reduce "Family" coverage to either "Parent and Child" or "Single" coverage. Please note that it is necessary to complete a *Health Benefits Program Application* to decrease your coverage and also to reinstate it once you return to work. Contact your benefits administrator or human resources representative for more information concerning coverage while on leave of absence.

Family and Medical Leave Act

Enrolled State and local employees are entitled to have their health benefits coverage continued at the expense of their employer while they are on family leave. You must remit to your employer, in advance, that portion of the premiums you normally pay, if any. To qualify for the federal Family and Medical Leave Act of 1993 (FMLA), you must have been employed for at least 12 months, have a personal illness, have a newborn child, or need to care for an ill family member. The FMLA defines the family member as a spouse, parent, or child. The FMLA provides up to 12 weeks in a 12-month period.

To qualify for the New Jersey Family Leave Act (NJFLA), you must have a need to care for an ill family member or a newborn child. There is no provision for an employee's own personal illness. The NJFLA provides up to 12 weeks in a 24-month period.

If an employee takes a leave for the care of a family member, both the FMLA and the NJFLA will run concurrently. If an employee takes a leave for maternity, they are on the FMLA. After their doctor releases them from their maternity leave, they can take the NJFLA for the care of the newborn child. This then provides the parent with up to 24 weeks of employer paid benefits.

Furlough

If you take an approved furlough, your health benefits coverage will continue for up to 30 days of furlough. However, you must remit to your employer, in advance, any contribution or portion of the premiums that you normally pay.

Extensions beyond the normal 30 furlough days are an exception and you will have to pay, in advance, for the full cost of health benefits coverage for your extended furlough, or drop your coverage for the entire benefit period in which you take an extended furlough day.

Workers' Compensation

If you have a Workers' Compensation award pending or have received an award of periodic benefits under Workers' Compensation or the Second Injury Fund, you and your dependents are entitled to have continued coverage at the same contribution level as when you were an active employee. You must remit to your employer, in advance, the portion of the premiums that you would normally pay, if any.

Suspension

If you are suspended from work, you are not eligible for employer-paid coverage. You may be eligible for coverage under COBRA (see page 48) under certain circumstances. Contact your benefits administrator or human resources representative for more information concerning coverage while on suspension.

Return from Leave of Absence

If your coverage has terminated while on an approved leave of absence, when you return from the leave, your benefits and those of your eligible family members are reinstated after you complete a Health Benefits Program Application (and include any required documentation for new dependents). You must complete this application within 60 days

after you return to work. Coverage becomes effective on the date you return to work if you are a State monthly or local employee, or on the first day of the pay period in which you return to work if you are a State biweekly employee. You may enroll in any plan at any level of coverage for which you are eligible when you return from an approved leave of absence. This reinstatement provision applies to all approved leaves.

If you retained your coverage at a reduced level while on an approved leave of absence, you may return to your former level of coverage or any other eligible level of coverage upon your return to work and the completion of a *Health Benefits Program Application*.

If you retained your coverage at a reduced level while on a leave of absence and were not actively at work during an Open Enrollment period, you may make Open Enrollment types of changes to your coverage when you return to work. These changes will be effective immediately upon your return to work.

If you are absent for a full pay period (State biweekly employee) and your coverage was terminated, or you purchased COBRA coverage while on leave, you must file a new *Health Benefits Program Application* **within 60 days** of the first day of your return to work. In addition, filing your application as soon as possible upon your return to work will help to ensure a timely re-enrollment.

End of Coverage

Coverage for you and your dependents will end if:

- you voluntarily terminate coverage (State employees, see "Effect of POP Participation" in the "Tax-Save" section on page 38);
- your employment terminates;
- your hours are reduced so you no longer qualify for coverage;