

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

NEW JERSEY
STATE HEALTH BENEFITS PROGRAM

NJ DIRECT

MEMBER HANDBOOK
for Employees and Retirees

PLAN YEAR 2008

ADMINISTERED FOR THE STATE HEALTH BENEFITS PROGRAM BY
HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY

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PLAN YEAR 2008
(APRIL 2008)

TABLE OF CONTENTS

INTRODUCTION	1
STATE HEALTH BENEFITS PROGRAM ELIGIBILITY	2
ACTIVE EMPLOYEE ELIGIBILITY	2
STATE EMPLOYEES	2
LOCAL EMPLOYEES	2
ELIGIBLE DEPENDENTS	3
MEDICARE COVERAGE WHILE EMPLOYED	4
RETIREE ELIGIBILITY	5
Aggregate Pension Membership Service Credit	6
Eligible Dependents of Retirees	6
Enrolling in the Retired Group of the SHBP	6
MEDICARE COVERAGE	7
A Member May be Eligible for Medicare for the Following Reasons	7
How to File a Claim If You Are Eligible for Medicare	8
GENERAL CONDITIONS OF THE PLAN	10
Medical Need and Appropriate Level of Care	10
PRECERTIFICATION OF BENEFITS IN-NETWORK AND OUT-OF-NETWORK	10
NJ DIRECT SERVICES REQUIRING PRECERTIFICATION	11
Predetermination of Benefits	13
UTILIZATION MANAGEMENT	14
Reasonable and Customary Allowances	14
Experimental or Investigational Treatments	14
PLAN BENEFITS	16
IN-NETWORK BENEFITS	16
Copayments	16
Coinsurance (In-Network)	16
OUT-OF-NETWORK BENEFITS	16
Deductible	17
Coinsurance (Out-of-Network)	17
OVERALL BENEFIT MAXIMUMS	18
Mental Health Benefit Maximums	18
COORDINATION OF BENEFITS	18

GENERAL BENEFITS	20
Acupuncture	20
Alcoholism and Substance Abuse	20
Allergy Testing and Treatment	20
Ambulance	20
Audiology Services	21
Automobile-Related Injuries	21
Biofeedback	21
Birthing Centers	21
Blood	22
Breast Reconstruction	22
Chiropractic Services	22
Congenital Defects	22
Dental Care	22
Diabetic Self-Management Education	23
Dialysis	23
Durable Medical Equipment and Supplies	24
Emergency Medical Services	24
Urgent and After Hours Care	24
Emergency Room	25
Federal Government Hospitals	25
Gynecological Care and Examinations	25
Home Health Care	25
Hemophilia Treatment	26
Hospice Care Benefits	26
Hospital-Based Weight Loss Programs	27
Immunizations	27
Infertility Treatment	27
Lead Poisoning Screening and Treatment	29
Lithotripsy Centers	29
Lyme Disease Intravenous Antibiotic Therapy	29
Mammography	29
Mastectomy Benefits	29
Maternity/Obstetrical Care	29
Maternity/Obstetrical Care for Child Dependents	29

Mental or Nervous Conditions and Substance Abuse	30
Outpatient Behavioral Health Benefits	30
Nutritional Counseling (In-Network Only)	30
Occupational Therapy	31
Organ Transplant Benefits	31
Pain Management	31
Pap Smears	31
Patient Controlled Analgesia (PCA)	31
Physical Therapy/Occupational Therapy	31
Physicals (In-Network Only)	32
Pre-Admission Hospital Review (In and Out-of-Network)	32
Pre-Admission Testing Charges	32
Prostate Cancer Screening (In-Network Only)	32
Scalp Hair Protheses	32
Second Surgical Opinion	32
Shock Therapy Benefits	32
Skilled Nursing Facility Charges	33
Speech Therapy Benefit	33
Surgical Services (Out-of-Network)	33
Temporomandibular Joint Disorder (TMJ) and Mouth Conditions	34
Vision Care Benefits	34
CHARGES NOT COVERED BY NJ DIRECT	35
THIRD PARTY LIABILITY	40
Repayment Agreement	40
Recovery Right	40
SUBROGATION AND REIMBURSEMENT	40
WHEN YOU HAVE A CLAIM	41
Submitting a Claim (In-Network)	41
Submitting a Claim (Out-of-Network)	41
Filing Deadline (Proof of Loss)	41
Itemized Bills are Necessary	42
Foreign Claims	42
Filling Out the Claim Form	42
MEDICARE CLAIM SUBMISSION	42
AUTHORIZATION TO PAY PROVIDER	42
QUESTIONS ABOUT CLAIMS	42

APPEAL PROCEDURES	43
UTILIZATION REVIEW APPEAL	43
CLAIMS APPEAL	43
First Level Appeal	43
Second Level Appeal	43
Commission Appeal	44
PRESCRIPTION DRUG BENEFITS	46
EMPLOYEE PRESCRIPTION DRUG PLAN	46
Plan Benefits	46
Prescription Drug Benefits Provided Through NJ DIRECT	46
RETIREE PRESCRIPTION DRUG COVERAGE	47
Medicare Part D	48
COBRA COVERAGE	49
CONTINUING COVERAGE WHEN IT WOULD NORMALLY END	49
COBRA Events	49
Cost of COBRA Coverage	50
Duration of COBRA Coverage	50
Employer Responsibilities Under COBRA	50
Employee Responsibilities Under COBRA	51
Failure to Elect COBRA Coverage	51
Termination of COBRA Coverage	51
APPENDIX I	53
SPECIAL PLAN PROVISIONS UNDER NJ DIRECT	53
WORK-RELATED INJURY OR DISEASE	53
MEDICAL PLAN EXTENSION OF BENEFITS	53
AUDIT OF DEPENDENT COVERAGE	53
TERMINATION FOR CAUSE	54
APPENDIX II	55
SUMMARY SCHEDULE OF SERVICES AND SUPPLIES	55
ELIGIBLE SERVICES AND SUPPLIES	55
COVERED SERVICES	55

APPENDIX III	61
GLOSSARY	61
APPENDIX IV	69
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT	69
Certification of Coverage	69
HIPAA Privacy	69
APPENDIX V	70
NOTICE OF PRIVACY PRACTICES	70
Protected Health Information	70
SHBP Uses and Disclosures of PHI	70
Member Rights	71
Questions and Complaints	72
APPENDIX VI	74
STATE HEALTH BENEFITS PROGRAM CONTACT INFORMATION	74
Addresses	74
Telephone Numbers	74
STATE HEALTH BENEFITS PROGRAM PUBLICATIONS	75
General Publications	75
SHBP Member Handbooks	76

An online version of this handbook containing current updates is available for viewing at: www.state.nj.us/treasury/pensions/shbp.htm Be sure to check the Division of Pensions and Benefits Internet home page at: www.state.nj.us/treasury/pensions for SHBP related forms, fact sheets, and news of any new developments affecting the benefits provided under the SHBP.

INTRODUCTION

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

The State Health Benefits Commission* (SHBC) establishes rules and regulations necessary for the administration of the State Health Benefits Program (SHBP). The SHBC includes the State Treasurer as the chairperson, the Commissioner of the Department of Banking and Insurance, the Commissioner of the Department of Personnel, a State employee representative chosen by the Public Employees' Committee of the AFL-CIO, and a representative chosen by the New Jersey Education Association (NJEA), or their designated representatives. The Director of the Division of Pensions and Benefits is the Secretary to the SHBC. The Division of Pensions and Benefits, specifically the Health Benefits Bureau and the Bureau of Policy and Planning, is responsible for the daily administrative activities of the SHBP.

NJ DIRECT provides both in-network and out-of-network benefits.

In-network care is provided through a network of providers which includes internists, general practitioners, pediatricians, specialists, and hospitals. Network providers offer a full range of services that include well-care and preventive services such as annual physicals, well-baby/well-child care, immunizations, mammograms, annual gynecological examinations, and prostate examinations. In-network services are generally covered in full after a member copayment. Most in-network hospital admissions are covered in full. For in-patient mental health hospitalization information see page 30.

Out-of-network benefits provide reimbursement for expenses for eligible services rendered for the treatment of illness and injury. Most out-of-network care is usually reimbursed at a percentage of the reasonable and customary allowance after an annual member deductible is met, see page 17. Out-of-network hospital admissions are subject to a separate \$200.00 deductible per admission.

Every effort has been made to ensure the accuracy of this Member Handbook, which describes the benefits provided in the contract with Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ). However, the New Jersey Statutes Annotated and the New Jersey Administrative Code govern the SHBP.

NJ DIRECT is self funded. Funds for the payment of claims and services come from funds supplied by the State, participating local employers, and members. NJ DIRECT is administered for the SHBP by Horizon BCBSNJ.

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

* *When the School Employees' Health Benefits Commission (SEHBC) becomes operational, a new Member Handbook specific to local education employees and retirees will be available.*

STATE HEALTH BENEFITS PROGRAM ELIGIBILITY

ACTIVE EMPLOYEE ELIGIBILITY

Enrollments, terminations, changes to coverage, etc. must be submitted through your employer to the SHBP. If you have any questions concerning eligibility provisions, you should call the Division of Pensions and Benefits' Office of Client Services at (609) 292-7524.

STATE EMPLOYEES

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

The following categories of State employees are also eligible for coverage in NJ DIRECT15.

State Part-Time Employees — Part-time employees of the State and part-time faculty at institutions of higher education that participate in the SHBP are eligible for coverage under the Program if they are members of a State-administered pension system. The employee or faculty member must pay the full cost of the coverage. Part-time employees will not qualify for employer or State-paid post-retirement health care benefits, but may enroll in the SHBP retired group at their own expense provided they were covered by the SHBP up to the date of retirement. See [Fact Sheet #66](#), *SHBP Coverage for Part-Time Employees*, for more information.

State Intermittent Employees — Certain intermittent State employees who have worked 750 hours in a Fiscal Year (July 1 - June 30) are eligible for coverage under the SHBP. Intermittent employees who maintain 750 hours of work per year continue to qualify for coverage in subsequent years. See [Fact Sheet #69](#), *SHBP Coverage for State Intermittent Employees*, for more information.

New Jersey National Guard — A member of the New Jersey National Guard who is called to State active duty for 30 days or more is eligible to enroll in the Program at the State's expense. Upon enrollment, the member may also enroll eligible dependents. The Department of Military and Veteran's Affairs is responsible for notifying eligible members and the Division of Pensions and Benefits of members who are eligible for coverage under the Program.

LOCAL EMPLOYEES

To be eligible for local employer coverage, you must be a full-time employee as determined by your employer or an appointed or elected officer as defined by [N.J.S.A. 40A:9](#) receiving a salary from a local employer (county, municipality, county or municipal authority, board of education, etc.) that participates in the SHBP. Each participating local employer defines the minimum number of hours necessary to be considered full-time. It can be no less than an average of 20 hours per week. The employer is required to file a resolution with the SHBP indicating the minimum hour requirement. Employment must also be for 12 months per year except for employees whose usual work schedule is 10 months per year (the standard school year).

The following categories of local employees are also eligible for coverage in NJ DIRECT15.

Local Part-Time Employees — A part-time faculty member employed by a county or community college that participates in the SHBP is eligible for coverage under the SHBP if they are members of a State-administered pension system. The faculty member must pay the full cost of the coverage. Part-time faculty members will not qualify for employer or State-paid post-retirement health care benefits, but may enroll in the SHBP retired group at their own expense provided they were covered by the SHBP up to the date of retirement. See [Fact Sheet #66](#), *SHBP Coverage for Part-Time Employees*, for more information.

ELIGIBLE DEPENDENTS

Your eligible dependents are your spouse, civil union partner or eligible same-sex domestic partner, and your eligible unmarried children.

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

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

Domestic Partner — 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 SHBP participating local public entity, who 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) is 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 — Refers to your unmarried children under age 23 who:

- live with you in a regular parent-child relationship;
- are away at school; or
- are divorced children living at home provided that they are dependent upon you for support and maintenance.

If you are a single parent, divorced, or legally separated, your children who do not live with you are eligible if you are legally required to support those children — [Affidavits of Dependency](#) and legal documentation are required with enrollment forms for these cases. If a *Qualified Medical Child Support Order* (QMCSO) is issued for your child, the health plan of the parent required to provide coverage according to the terms of the QMCSO will be the primary plan for that child. The employer must be notified of the QMCSO and a [NJ State Health Benefits Program Application](#) submitted electing coverage for the child within 60 days of the date the order was issued.

Stepchildren, foster children, legally adopted children, and children in a guardian-ward relationship are also eligible provided they live with you, are under the age of 23 and are substantially dependent upon you for support and maintenance. [Affidavits of Dependency](#) and legal documentation are required with enrollment forms for these cases.

Coverage for an enrolled child will end when the child marries, enters into a civil union or domestic partnership, moves out of the household, turns age 23, obtains coverage under the SHBP as an employee, or is no longer dependent on you for support and maintenance. Coverage ends on December 31 of the year in which the child turns age 23 (see the “COBRA” section on page 49 for continuation of coverage provisions).

Dependent Children with Disabilities — 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. To request continued coverage, contact the Office of Client Services at (609) 292-7524 or write to the Division of Pensions and Benefits, Health Benefits Bureau, 50 West State Street, P. O. Box 299, Trenton, New Jersey 08625 for a *Continuance for Dependent with Disabilities* form. The form and proof of the child's condition must be given to the Division no later than 31 days after the date coverage would normally end. Since coverage for children ends on December 31 of the year they turn 23, 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, and (2) the child continues to be disabled, and (3) the child is unmarried or does not enter into a civil union or domestic partnership, and (4) the child remains dependent on you for support and maintenance. You will be contacted periodically to verify that the child remains eligible for continued coverage.

Continued Coverage for Over Age Children — If you have a covered child turning age 23, you will receive a COBRA notification letter prior to the termination of your child's coverage. The notice outlines the right to purchase continued health coverage through COBRA, gives the date coverage will end, and the period of time over which coverage may be extended (usually 36 months). COBRA premiums may be less than the premiums for Chapter 375 coverage (see below).

Under the provisions of Chapter 375, P.L. 2005, certain over age children may be eligible for coverage under the SHBP until age 30 at their own cost pursuant to N.J.A.C. 17:9-13. (See [Fact Sheet #74](#), *SHBP Coverage of Children to Age 30 Under Chapter 375*, for more details.)

This includes a child by blood or law who:

- is under the age of 30;
- unmarried or not a partner in a civil union or domestic partnership;
- has no dependent(s) of his or her own;
- is a resident of New Jersey or is a full-time student at an accredited public or private institution of higher education; and
- is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare.

MEDICARE COVERAGE WHILE EMPLOYED

In general, it is not necessary for a Medicare-eligible employee, spouse, civil union or domestic partner, or dependent child(ren) to be covered by Medicare while the employee remains actively at work. However, if you or your dependents become eligible for Medicare due to End Stage Renal Disease (ESRD) you and/or your dependents must enroll in Medicare Parts A and B even though you are actively at work. For more information, see “Medicare Coverage” beginning on page 7 in the “Retiree Eligibility” section.

RETIREE ELIGIBILITY

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

- Full-time State employees, employees of State colleges/universities, autonomous State agencies and commissions, or local employees who were covered by, or eligible for, the SHBP at the time of retirement.
- Part-time State employees and part-time faculty at SHBP participating institutions of higher education if they were enrolled in the SHBP at the time of retirement.
- Full-time employees enrolled in the Teachers' Pension and Annuity Fund (TPAF) and full-time school board or county college employees enrolled in the Public Employees' Retirement System (PERS) who retire with **25 years or more** of service credit in TPAF or PERS or who retire on a disability retirement, even if their employer did not cover its employees under the SHBP. This includes those who elect to defer retirement with 25 or more years of service credit in TPAF or PERS (see "Aggregate of Service Credit" on page 6).
- Full-time employees enrolled in the TPAF and full-time school board or county college employees enrolled in the PERS who retire with **less than 25 years** of service credit from an employer that participates in the SHBP.
- Full-time employees enrolled in the TPAF and PERS who retire from a board of education, vocational/ technical school, or special services commission; maintain participation in the health benefits plan of their former employer; and are eligible for and enrolled in Medicare Parts A and B.
- Participants in the Alternate Benefit Program (ABP) who retire with at least 25 years of credited ABP service or those who are on a long-term disability.
- Certain local policemen or firemen who retire with 25 years or more of service credit in the Police and Firemen's Retirement System (PFRS), the Consolidated Police and Firemen's Pension Fund, or from the PERS as a law enforcement officer or retiring on a disability retirement if the employer does not provide any payment or compensation toward the cost of the retiree's health benefits. A qualified retiree may enroll at the time of retirement or when he or she becomes eligible for Medicare. See [Fact Sheet #47](#), *SHBP Retired Coverage Under Chapter 330*, for more information.
- Surviving spouses, civil union partners, eligible same-sex domestic partners, and children of PFRS members or State Police Retirement System (SPRS) members killed in the line of duty.

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

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

time you terminated your employment), or a part-time State employee or part-time faculty member who is **enrolled** in the SHBP immediately preceding the effective date of your retirement.

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

Note: If you continue group coverage through COBRA (see the “COBRA” section on page 49) — or as a dependent under other coverage through a public employer — until your retirement becomes effective, you will be eligible for retired coverage under the SHBP.

Aggregate Pension Membership Service Credit

Upon retirement, a full-time employee of the State, board of education, or county college who has 25 years or more of service credit, is eligible for State-paid health benefits under the SHBP. A full-time employee of a local government who has 25 years or more of service credit whose employer is enrolled in the SHBP **and** has chosen to provide post-retirement medical coverage to its retirees is eligible for employer-paid health benefits under the SHBP. A retiree under the SHBP may receive this benefit if the 25 years of service credit is from **one or more** State or locally-administered retirement systems and the time credited is non-concurrent.

Eligible Dependents of Retirees

Dependent eligibility rules for Retired Group coverage are the same as for Active Group coverage except for the Medicare requirements beginning on page 7.

Enrolling in the Retired Group of the SHBP

The SHBP is notified when you file an application for retirement with the Division of Pensions and Benefits. If eligible, you will receive a letter inviting you to enroll for coverage in the SHBP’s Retired Group. Early filing for retirement is recommended to prevent any lapse of SHBP coverage or delay in eligibility determination. If you do not submit a [Retired Coverage Enrollment Application](#) at the time of retirement, you will not generally be permitted to enroll for coverage at a later date. See [Fact Sheet #11, Enrolling in the SHBP When You Retire](#), for more information.

Additional restrictions and/or requirements may apply when enrolling in the Retired Group of the SHBP. Be sure to carefully read the “Retiree Enrollment” section of the [SHBP Summary Program Description](#).

MEDICARE COVERAGE

IMPORTANT: A Retired Group subscriber and/or dependent(s) who are eligible for Medicare coverage by reason of age or disability must be enrolled in both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to enroll or remain in SHBP Retired Group coverage.

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

IMPORTANT: If a provider is not registered with or opts out of Medicare, no benefits are payable under the SHBP for the provider's services. Verify that your provider is registered with and has not opted out of the Medicare Program.

A Member May be Eligible for Medicare for the Following Reasons

- ***Medicare Eligibility by Reason of Turning Age 65***

This applies to a retiree or a retiree's covered spouse/partner who turns age 65.

A member is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the member is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.

The retired group health plan is the secondary plan.

- ***Medicare Eligibility by Reason of Disability***

This applies to a subscriber or dependent who is under age 65 and has been receiving Social Security Disability benefits for 24 months.

The retired group health plan is the secondary plan to Medicare when the member is the subscriber, is under age 65, and is retired, or when the dependent is covered under Medicare and not covered under any active employer group plan.

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

A member may qualify for Medicare because of treatment for End Stage Renal Disease (ESRD). When a member becomes eligible for Medicare solely on the basis of ESRD, the Medicare eligibility can be segmented into three parts: (1) an initial three-month waiting period; (2) a "coordination of benefits" period; and (3) a period where Medicare is primary.

Three-month waiting period

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

Coordination of benefits period

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

When Medicare is primary

After the 30-month coordination of benefits period ends, **Medicare becomes the primary payer and the group health plan is secondary.**

The rules listed above, known as the Medicare Secondary Payer (MSP) rules are federal regulations that determine whether Medicare pays first or second to the group health plan.

How to File a Claim If You Are Eligible for Medicare

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

New Jersey Physicians or Providers:

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

Retirees Enrolled in Medicare Who Move Outside the United States

Medicare does not cover services outside the United States. For SHBP members who reside outside the United States, NJ DIRECT covers services as if NJ DIRECT were primary.

Members who reside outside the United States must still maintain their Medicare coverage (Parts A and B) in order to be covered under the SHBP.

Members, who reside outside the United States, even if they reside in a country with a national health plan, should consider that if they travel outside their country of residence they will still need coverage. In order to have SHBP coverage at any time in the future, the member must stay enrolled in the SHBP, since once a member terminates coverage they will not be reinstated.

GENERAL CONDITIONS OF THE PLAN

All benefits listed in this handbook may be subject to limitations and exclusions as described in subsequent sections. All pertinent parts of this handbook should be consulted regarding a specific benefit.

Even though a service or supply may not be described or listed in this handbook, that does not mean the service or supply is eligible for benefits under NJ DIRECT.

NJ DIRECT will pay only for eligible services or supplies that meet the following conditions:

- Are medically needed at the appropriate level of care (see below) for the medical condition. (When there is a question as to medical need, the decision on whether the treatment is eligible for coverage will be made by Horizon BCBSNJ.)
- Are listed in the “Eligible Services and Supplies” section on page 55.
- Are ordered by an eligible provider for treatment of illness or injury.
- Were provided while you or your eligible covered dependents were covered by NJ DIRECT.
- Are not specifically excluded (listed in the “Charges Not Covered by the Plan” section on page 35).

When you use an out-of-network provider, all services, supplies, tests, etc. prescribed by the out-of-network provider, including hospitalization, are reimbursed at a percentage of the reasonable and customary allowance after deductibles and coinsurance have been met. The member is responsible for any amount charged by the physician that is above and beyond the reasonable and customary allowance in addition to deductibles and coinsurance.

Medical Need and Appropriate Level of Care

The medical need and appropriate level of care for any service or supply is determined by Horizon BCBSNJ and must meet **each** of these requirements:

- It is ordered by an eligible provider for the diagnosis or the treatment of an illness or injury.
- The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use.
- That it is the most appropriate level of service or supply considering the potential benefits and possible harm to the patient.

See also “Experimental or Investigational Treatments” on page 14.

PRECERTIFICATION OF BENEFITS IN-NETWORK AND OUT-OF-NETWORK

A precertification is required for certain services and all inpatient admissions. Failure to obtain a precertification may result in benefits being denied. Participating physicians will obtain pre-certification on your behalf. Horizon BCBSNJ will conduct a review of any services that were not precertified to determine eligibility. When precertification is not obtained, eligible services will be paid at the out-of-network level of benefits. Furthermore, the amount that you are required to pay will not apply to the out-of-pocket maximums because the required certification was not obtained.

NJ DIRECT SERVICES REQUIRING PRECERTIFICATION

Accidental Dental Injuries

Air Ambulance

Cancer Clinical Trials

Cochlear Implants

Durable Medical Equipment (DME), Prosthetics and Orthotics (referenced below)

- Electric, customized or motorized wheelchairs and scooters, and powered accessories
- Electric beds/Clinitron/Powered Hospital beds/Air mattresses/Powered Accessories
- Enteral formula
- Bone stimulators
- Neurostimulators
- Limb and Torso prosthetics
- Voice Prosthetic Devices
- Lymphadema Pumps
- External defibrillators
- All rentals

Inpatient Admissions:

- All acute care confinements, exclusive of maternities, including:
 1. Surgical admissions
 2. Medical admissions
 3. Hospice admission
 4. All Skilled Nursing Facility (SNF) confinements
- All Rehabilitation facility confinements
- All Sub-Acute confinements
- Mental health and substance abuse confinements (including Residential, Partial Hospitalizations and Intensive Out-Patient Admissions.)

Home Health Care Services

Home Hospice Services

Hospital Based Weight Loss Programs

Hyperbaric Oxygen Therapy

Infertility Services

- Gamete intrafallopian transfer
- In vitro fertilization

- Zygote intrafallopian transfer
- Artificial insemination
- Hysterosalpingography

Home Infusion (IV) Therapy

Mental Health and Alcohol and Substance Abuse Services

Specific Medications administered in a physician's office or dialysis facility (review performed by Care Core National)

- Aranesp
- Epogen
- Procrit

Pain Management

Private Duty Nursing in the Home (Inpatient PDN is ineligible)

Radiology (review services performed by Care Core National)

- CT/CTA Scans
- MRI/MRA
- Nuclear Medicine/Nuclear Cardiology
- PET and PET/CT Scans
- Echo Stress Tests
- Diagnostic Left Heart Catheterization.

Reconstructive Procedures that may be considered Cosmetic:

- Blepharoplasty/Canthopexy/Canthoplasty
- Excision of excessive skin due to weight loss
- Rhinoplasty/rhytidectomy
- Pectus excavatum repair
- Breast reconstruction/enlargement
- Breast reduction/mammoplasty
- Lipectomy or excess fat removal
- Sclerotherapy or surgery for varicose veins
- Facial reconstruction or repair including:
 - ✓ Orthognathic surgery
 - ✓ Bone grafts
 - ✓ Osteotomies
 - ✓ Surgical management of temporomandibular joint
- Any other potentially cosmetic procedure

Specialty Pharmaceuticals

Spinal Disk Surgeries (including but not limited to):

- Percutaneous Laser Discectomy
- Nucleoplasty
- Spinal Fusion

Surgery for Morbid Obesity (including but not limited to):

- Gastroplasty
- Gastric Bypass
- Bariatric Procedures

Therapy Services:

- Cognitive Therapy
- Occupational Therapy
- Physical Therapy
- Speech Therapy

Transplants

- Lung
- Liver
- Heart
- Pancreas
- Autologous Bone Marrow
- Cornea
- Kidney
- Autologous Chondrocyte Transplants
- Uvulopalatopharyngoplasty (UPPP)

Predetermination of Benefits

A predetermination for any service may be obtained ***in writing*** in advance of services being rendered. The written request will need to include the provider's name, address, and phone number, the diagnosis, a description of the services to be rendered, and the anticipated charges. Telephone contact with Horizon BCBSNJ or the Division of Pensions and Benefits about coverage does not constitute a predetermination of benefits. If the actual services rendered differ from those described in the written request, the predetermination of benefits will have no effect. A predetermination is valid for one year from the date issued. All requests for written predeterminations must include all necessary medical documentation and must be presented to Horizon BCBSNJ 3 to 4 weeks prior to the services being rendered. If Horizon BCBSNJ requires additional medical information, the written response may be delayed.

UTILIZATION MANAGEMENT (Medical Management and Review)

Both in-network and out-of-network treatment is subject to Utilization Management (UM), a process used to ensure that treatment is medically needed and provided at the appropriate level of care. When the treatment is proposed by an in-network provider, the provider is responsible for the UM contact. Benefits are payable for in-network treatment when they are provided by an in-network provider, the UM organization has been notified to review the treatment, and the UM organization has approved the treatment.

Out-of-network benefits that are actually payable will also depend on whether the patient or patient's provider has or has not contacted the UM organization in regard to proposed medical treatment and whether the UM organization agrees that the treatment is needed and at the appropriate level of care. If the member is utilizing a non-participating physician, they should request their non-participating physician to contact Utilization Management at the number listed on their ID card (1-800-664-2583). If a member calls this number to request precertification, the UM organization's Precertification Department will request the phone number of the physician and will contact the physician to obtain the clinical information needed in order to review the services requested.

For out-of-network benefits when the patient has failed to contact the UM organization at Horizon BCBSNJ, treatment will be considered not certified and expenses will not be applied to the annual out-of-pocket maximum. However, if the treatment is eligible, reimbursement will be made at appropriate 70/80 percent of reasonable and customary allowances after any deductible has been met.

Reasonable and Customary Allowances (for Out-of-Network Services)

NJ DIRECT covers only reasonable and customary allowances, which are determined by the Prevailing Healthcare Charges System (PHCS) fee schedule. This schedule is based on actual charges by physicians in a specific geographic area for a specific service. If your physician charges more than the reasonable and customary allowance, you will be responsible for the full amount above the reasonable and customary allowance in addition to any deductible and coinsurance you may be required to pay.

Experimental or Investigational Treatments

NJ DIRECT **does not** cover treatment that is considered experimental or investigational. Charges in connection with such a service or supply are also not covered. For the purpose of this exclusion, a service or supply will be considered experimental or investigational if Horizon BCBSNJ determines that one or more of the following is true.

1. The service or supply is under study or in a clinical trial to evaluate its toxicity, safety, or efficacy for a particular diagnosis or set of indications. Clinical trials include but are not limited to phase I, II, and III clinical trials, with the exception of approved cancer trials.
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for a particular diagnosis or set of indications before it is used outside clinical trials or other research settings. Horizon BCBSNJ will determine this based on:
 - Published reports in authoritative medical literature; and

- Regulations, reports, publications, and evaluations issued by US government agencies such as the Agency for Health Care Research and Quality, the National Institutes of Health, and the federal Food and Drug Administration (FDA).
3. The provider's institutional review board acknowledges that the use of the service or supply is experimental or investigational and subject to that board's approval.
 4. The provider's institutional review board requires that the patient, parent, or guardian give an informed consent stating that the service or supply is experimental or investigational, part of a research project or study, or federal law requires such consent.
 5. Research protocols indicate that the service or supply is experimental or investigational. This item applies for protocols used by the patient's provider as well as for protocols used by other providers studying substantially the same service or supply.
 6. The service or supply is not recognized by the prevailing opinion within the appropriate medical specialty as an effective treatment for the particular diagnosis or set of indications.
 7. Additionally, if it is a drug, device, or other supply that is subject to FDA approval it will be considered experimental and investigational if it:
 - Does not have FDA approval for sale and use in the United States (that is, for introduction into and distribution in interstate commerce); or
 - Has FDA approval only under the Treatment Investigational New Drug regulation or a similar regulation; or
 - Has FDA approval, but is being used for an indication or at a dosage that is not an acceptable off-label use. Horizon BCBSNJ will determine if a certain use is an accepted off-label use based on published reports in peer-reviewed, authoritative medical literature and entries in the following drug compendia: The American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, and the United States Pharmacopoeia Dispensing Information.

PLAN BENEFITS

Unless otherwise indicated, NJ DIRECT refers to both NJ DIRECT10 and NJ DIRECT15.

IN-NETWORK BENEFITS

You can benefit most from NJ DIRECT when you obtain your care from in-network providers. When you are treated in-network, you are covered for treatment of illness or injury in addition to well-care and preventive services. NJ DIRECT will pay, in most cases, the full cost after an appropriate member copayment per visit. **If you do not contact NJ DIRECT for prior precertification for selected services (see page 10) your claims will be paid at the out-of-network level of benefits and the amount that you are required to pay will not apply to the out-of-pocket maximums.**

Copayments

Copayments apply to in-network services unless otherwise indicated.

- **NJ DIRECT10** has a **\$10.00** copayment.
- **NJ DIRECT15** has a **\$15.00** copayment.

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 copayment. 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 full in most cases. 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 in New Jersey, use the SHBP Unified Provider Directory. To find a participating physician outside of New Jersey, contact Horizon BCBSNJ directly.

Coinsurance (In-Network)

Select in-network services require the member to pay coinsurance instead of a copayment. Examples of the types of service requiring the coinsurance are durable medical equipment, ambulance services, and prosthetic devices. Once the member reaches the in-network out-of-pocket annual maximum of \$400, NJ DIRECT will pay 100 percent of the cost of these types of covered services.

OUT-OF-NETWORK BENEFITS

NJ DIRECT includes an option for using out-of-network providers. When you exercise this out-of-network option, you will be responsible for deductibles and a percentage of coinsurance based on a reasonable and customary fee schedule, and any amount exceeding the reasonable and customary allowances for all services. NJ DIRECT's out-of-network benefits do not cover most well-care or preventive care.

The out-of-network determination is based on the participating status of the provider such as the physician, specialist, therapist, hospital/facility rendering the service. For example, if you utilize a non-participating doctor and services are provided at an in-network hospital, the doctor will be paid at the out-of-network level as indicated above and the hospital will be paid at the in-network level.

Deductible

NJ DIRECT has one annual deductible for out-of-network benefits that the individual or family must meet before an out-of-network charge is paid. The annual deductible for out-of-network services is \$100 per individual and \$250 per family. The actual maximum deductible applied varies with the level of coverage you elect:

- **Single** – \$100
- **Member and Spouse/Partner** – \$100 per person
- **Family or Parent and Child(ren)** – \$250 in aggregate for all family members, but no more than \$100 per person

The benefit year in which the deductible is measured runs from January 1 to December 31. However, if treatment for an illness or injury is provided during the last three months of the year, the allowable expenses that were applied toward the deductible may be allowed to 'carry over' toward meeting the deductible for the following year.

Deductible Examples:

Single Coverage — You incur an out-of-network doctor's office visit in April 2008 and the allowable expense is \$100. This is your first claim of the year and no other calendar year deductible has been met; therefore the \$100 allowable expense is applied to and satisfies the deductible for 2008.

Family Coverage/Aggregate — You and two covered family members incur an out-of-network doctor's office visit in May 2008. The allowable expense is \$85 per visit or \$255 for all three visits. These are your family's first claims of the year and no other calendar year deductible has been met; therefore \$85 for the first two visits is applied toward the family deductible (\$170) along with \$80 from the third visit (\$250.) The \$250 family deductible is met for 2008.

Family Coverage/Individual — You or a family member incur an out-of-network doctor's office visit in May 2008 and the allowable expense is \$100. This is the first claim of the year and no other calendar year deductible has been met, therefore the \$100 allowable expense is applied to and satisfies the individual deductible for 2008. The \$100 allowable expense is also applied toward the \$250 family deductible for 2008.

Deductible Carryover — You incur an out-of-network doctor's office visit in October 2008 and the allowable expense is \$90. This is your first claim of the year and no other calendar year deductible has been met; therefore the full \$90 allowable expense is applied to the deductible for 2008. Since this amount was applied in the last three months of 2008, the full \$90 will carry over and be applied toward meeting the 2009 deductible as well.

Coinsurance (Out-of-Network)

NJ DIRECT will pay a percentage of the reasonable and customary allowance for eligible out-of-network charges. You are required to pay the remaining percentage of the reasonable and customary allowance as well as the difference between the allowance and the

provider's charges. When your out-of-pocket amount for the year totals \$2,000 per individual or \$5,000 per family, the plan will pay 100 percent of the reasonable and customary allowance for eligible services.

The member is responsible for any amount above the reasonable and customary allowance in addition to deductible and coinsurance liability. Expenses for ineligible services and charges in excess of the reasonable and customary allowance do not count toward your out-of-pocket maximum. Eligible services and precertified treatment count toward the NJ DIRECT maximum out-of-pocket expense level. Expenses for ineligible services and charges in excess of reasonable and customary allowances do not count toward your out-of-pocket maximums and are your financial responsibility.

OVERALL BENEFIT MAXIMUMS

For **in-network** services there is **no lifetime benefit maximum**.

For **out-of-network** services, there is a lifetime maximum benefit of **\$1,000,000** for diagnosis and treatment of illness and injuries, with an automatic limited restoration feature. If your coverage under the plan ends and begins again at a later date, your individual lifetime maximum benefit resumes at the same level it was when your coverage ended. In addition, if you transferred to NJ DIRECT from NJ PLUS or the Traditional Plan, your lifetime maximum level transfers with you. The \$1,000,000 maximum applies to all covered services and supplies incurred under any NJ DIRECT option.

Mental Health Benefit Maximums

There is a \$15,000 annual mental health benefit maximum for non-biologically based mental health conditions as well as a \$50,000 lifetime mental health benefit maximum. There is a restoration benefit that restores up to \$2,000 per year up to a lifetime maximum of \$50,000.

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

COORDINATION OF BENEFITS

For group plans that do have a Coordination of Benefits provision, the following rules determine which plan is primary.

- If you, the active employee, are the patient, NJ DIRECT is primary for you. If your spouse/partner is the patient, and covered under a health plan provided through his or her employer as an active employee, that plan is the primary plan for them.
- If a member has coverage as an active employee and additional coverage as a retiree the coverage through active employment is primary to retiree coverage.
- When Medicare is involved (except for ESRD; see page 7), the benefits of the plan that covers an active employee and/or his or her dependents will be considered primary before the benefits of a plan that covers a laid-off or a retired employee and his or her dependents.
- If a dependent child is the patient and is covered under both parents' plans, the following birthday rule will apply.

Under the birthday rule, the plan covering the parent whose birthday falls earlier in the year will have primary responsibility for the coverage of the dependent children. For example, if the father's birthday is July 16 and the mother's birthday is May 17, the mother's plan would be the primary plan for the couple's dependent children because the mother's birthday falls earlier in the year. If both parents have the same birthday, the plan covering the parent for the longer period of time will be primary.

This birthday rule regulation affects all carriers and all contracts which contain Coordination of Benefits provisions. It applies only if both contracts being coordinated have the birthday rule provision. If only one contract has the birthday rule and the other has the gender rule (father's contract is always primary), the contract with the gender rule will prevail in determining primary coverage.

- If two or more plans cover a person as a dependent child of separated or divorced parents, benefits for the dependent child will be determined in the following order.
 - ✓ The plan of the parent with custody is primary; followed by
 - ✓ The plan of the spouse/partner of the parent with custody of the child; then
 - ✓ The plan of the parent not having custody of the child.
- If it has been established by a court decree — Qualified Medical Child Support Order (QMCSO) — that one parent has responsibility for the child's health care expenses, then the plan of that parent is primary.
- If none of the rules listed above determine the order of benefits, the plan that has covered the patient for the longer period is the primary plan.

NJ DIRECT will provide its regular benefits in full when it is the primary plan. As a secondary plan, NJ DIRECT will provide reimbursement up to its regular benefit which when added to the benefits under other group plans will not exceed 100 percent of the member's liability.

There is no Coordination of Benefits between NJ DIRECT10 and NJ DIRECT15.

Please note: The Coordination of Benefits rules described above may change if Medicare is involved. Please refer to the Medicare sections on page 4 and page 7 for more information.

Please note: There is **no** coordination of benefits between two freestanding prescription drug plans.

GENERAL BENEFITS

This section lists the general treatments, services, and supplies that NJ DIRECT will consider. Expenses for these services or supplies are subject to reasonable and customary allowances; medical need and appropriate level of care; utilization review; the Schedule of Services and Supplies; and benefit limitations and exclusions. A “Summary Schedule of Services and Supplies” is on page 55 for your reference. Select services require precertification (see page 10 for details). If a service is not listed, please contact Horizon BCBSNJ directly to find out if it is covered.

The fact that an item or service is not listed below, does not automatically make the service or item covered under the NJ DIRECT plans.

Acupuncture

Acupuncture treatment is covered when the services are for **a diagnosis related to pain management** and are rendered by a Licensed Acupuncturist or Licensed Medical Doctor (M.D., D.O.). Acupuncture treatment is subject to maintenance and supportive care provisions.

Examples of acupuncture services that are **not** eligible under NJ DIRECT include weight loss and smoking cessation.

Alcoholism and Substance Abuse

NJ DIRECT covers the treatment of Alcoholism and Substance Abuse the same way it would any other illness, if such treatment is prescribed by an eligible provider and it is deemed to be medically needed and at the appropriate level of care. For scheduled or emergency treatment relating to substance abuse, or alcoholism, you or your provider **MUST** call 1-800-991-5579. You **must** obtain a precertification for all admissions.

Inpatient or outpatient treatment may be furnished as follows:

- Care provided in a state licensed health care facility.
- Care provided in a licensed detoxification facility.
- Care provided at a licensed and state approved residential treatment facility, under a plan which meets minimum standards of care.

Psychotherapy to treat alcohol or substance abuse is covered under mental health and is subject to the annual and lifetime mental health maximum benefits.

Allergy Testing and Treatment

Most commonly used methods of allergy testing are covered. However, some methods are subject to medical need at the appropriate level of care review before eligibility can be determined. This includes, but is not limited to, the following tests:

- RAST (Radioallergosorbent Testing)
- MAST (Multiple Radioallergosorbent Testing)
- FAST (Fluorescent Allergosorbent Testing)
- ELISA (Enzyme-Linked Immunosorbent Assay)

Ambulance

Ambulance use for local **emergency** transport to the nearest facility equipped to treat the emergency condition is covered subject to medical need at the appropriate level of care. If

emergency air transport is needed, it must be medically necessary and approved by having your physician call Horizon BCBSNJ at 1-800-664-2583.

NJ DIRECT **does not cover** chartered air flights, non-emergency air ambulance, invalid coach, transportation services, or other travel, lodging, or communication expenses of patients, providers, nurses, or family members.

Audiology Services

Audiology services are covered when rendered by a physician or a licensed audiologist, when such services are determined to be medically necessary and at the appropriate level of care. Pre-approval is required for these services. See exclusions for hearing aids and hearing examinations.

Automobile-Related Injuries

NJ DIRECT will provide secondary coverage to your mandatory New Jersey Personal Injury Protection (PIP) unless NJ DIRECT has been elected as the primary coverage by or for the employee covered under NJ DIRECT. This election is made by the named insured under the PIP program and affects that member's family members who are not themselves the named insured under another auto policy. NJ DIRECT may be primary for one member, but not for another if the individuals have separate auto policies and have made different selections regarding primacy of health coverage.

If NJ DIRECT is primary to PIP or other automobile insurance coverage, benefits are paid in accordance with the terms, conditions, and limits set forth in your contract and only for those services normally covered under NJ DIRECT.

Please note: If you elect to have NJ DIRECT as primary to PIP, prior notification to NJ DIRECT is not required. Upon receipt of an auto related claim, NJ DIRECT will request the submission of written documentation, such as a copy of your policy declaration page, for verification of your selection.

If NJ DIRECT is one of several health insurance plans which provide benefits for automobile related injuries and the covered employee has elected health coverage as primary, these plans may coordinate benefits as they normally would in the absence of this provision.

If NJ DIRECT is secondary to PIP, the actual benefits payable will be the lesser of:

- The remaining uncovered allowable expenses after PIP has provided coverage, subject to medical need at the appropriate level of care and other provisions, after application of deductibles and coinsurance, or
- The actual benefits that would have been payable had NJ DIRECT been primary.

Biofeedback

Biofeedback to treat a medical or **biologically-based mental illness** diagnosis is covered the same as any other general condition. All mental health diagnoses, other than for biologically-based mental illness, are subject to mental health annual and lifetime maximums.

Birthing Centers

As an alternative to conventional hospital delivery room care for low-risk maternity patients, NJ DIRECT pays for care in participating birthing centers. Services, routinely provided by the birthing centers, including prenatal, delivery, and postnatal care, will be covered in full if the delivery takes place at the center. If complications occur during labor, and delivery occurs in an approved hospital because of the need for emergency or inpatient care, this

care will also be covered in full. Contact Horizon BCBSNJ at 1-800-414-7427 to identify eligible birthing centers near you.

Blood

Blood, blood products, blood transfusions, and the cost of testing and processing blood are covered. NJ DIRECT does not pay for blood which has been donated or replaced on behalf of the patient.

Breast Reconstruction

If you are receiving benefits in connection with a mastectomy and elect to have breast reconstruction along with that mastectomy, NJ DIRECT will provide coverage for the following:

- Reconstruction of the breast on which the mastectomy was performed.
- Prosthesis(es).
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Physical complications at all stages of the mastectomy, including lymphedemas.

Chiropractic Services

There is a 30-visit per calendar year benefit maximum for chiropractic services. The chiropractor must be licensed, the services must be appropriate for the diagnosed condition(s), and must fall within the scope of practice of a chiropractor in the state in which he or she is practicing.

Congenital Defects

Surgical procedures that are necessary to correct a congenital birth defect which significantly impairs function are covered.

Dental Care

NJ DIRECT provides benefits for the removal of bony impacted molars, and will pay for the treatment of accidental injuries, and treatment for mouth tumors if medically necessary.

NJ DIRECT may provide coverage for the treatment of accidental dental injuries. You must have been covered by NJ DIRECT at the time the injury occurred. An accidental dental injury is considered an injury to teeth (must be sound natural teeth) which is caused by an external factor such as damage caused by being hit by a hockey puck or having teeth broken in a fall on the ice.

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

Dental services required as the result of medical conditions or medical services rendered such as: radiation, chemotherapy and long term use of prescription drugs are not eligible. These dental services should be submitted to your Dental Plan.

Hospital and anesthesia charges incurred for dental services that are medically needed and at the appropriate level of care are covered for severely disabled members and children

when convincing documentation is submitted in advance for the medical need for the hospitalization/anesthesia services. Charges for the actual dental procedures would not be eligible for benefits.

Diabetic Self-Management Education

Benefits, limited to four visits per year, are included for expenses incurred for diabetes self-management education to ensure that a person with diabetes is educated as to the proper self-management and treatment of the member's condition.

Benefits for self-management education and education relating to diet shall be limited to medically necessary visits upon:

- The diagnosis of diabetes;
- The diagnosis by a physician or nurse provider/clinical nurse specialist of a significant change in your symptoms or conditions which necessitate changes in your self-management; and
- Determination by a physician or nurse provider/clinical nurse specialist that reeducation or refresher education is necessary.

Diabetes self-management education is covered when provided by:

- A physician, nurse provider, or clinical nurse specialist;
- A health care professional such as a registered dietician that is recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators; or
- A registered pharmacist in New Jersey qualified with regard to management education for diabetes by any institution recognized by the Board of Pharmacy of the State of New Jersey.

Benefits are provided for expenses incurred for the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a physician or nurse provider/clinical nurse specialist:

- Blood glucose monitors
- Test strips for glucose monitors and visual reading and urine testing strips
- Insulin
- Injection aid cartridges
- Syringes
- Insulin pumps
- Insulin infusion devices
- Alcohol wipes

Dialysis

Dialysis is covered when the services are provided and billed by an eligible hospital, by a freestanding dialysis center, or by an eligible home health care agency. The facility must make arrangements for training, equipment rental, and supplies on behalf of the patient. Home dialysis will be considered when there is documented evidence that the services cannot be performed in an outpatient facility. Ambulance transportation/invalid coach service to and from dialysis sessions is not eligible for coverage.

Durable Medical Equipment and Supplies

Charges for the rental of durable medical equipment needed for therapeutic use are covered. NJ DIRECT may cover the purchase of such items when it is less costly and more practical than renting such items. NJ DIRECT does not cover the rental or purchase of any items that do not fully meet the definition of durable medical equipment. For in and out-of-network services it is recommended that costly durable medical equipment be approved by Horizon BCBSNJ prior to purchase.

NJ DIRECT also covers eligible supplies including surgical dressings, blood and blood plasma, artificial - limbs, larynx and eyes, casts, Inherited Metabolic Disease medical food, certain non-standard infant formula (under one year of age), splints, trusses, braces, crutches, respirator oxygen and rental of equipment for its use.

Deluxe models of DME items such as, but not limited to, wheelchairs are not eligible for benefits.

Emergency Medical Services

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

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

With respect to emergency services furnished in a hospital emergency department, Horizon BCBSNJ shall not require prior authorization for the provision of such services if the member arrived at the emergency medical department with symptoms that reasonably suggested an emergency condition based on the judgment of a prudent layperson. All procedures performed during the evaluation (triage) and treatment of an emergency medical condition shall be covered.

If you find yourself in an emergency situation and notification prior to treatment is not reasonably possible, go directly to the nearest emergency facility. All such treatment received during the first 48 hours after the onset of the medical emergency will be eligible for in-network benefits, regardless of whether such treatment is received in or out of the service area or whether such treatment is furnished by a network provider.

Urgent and After Hours Care

Urgent care is medically necessary care for an unexpected illness or injury that should be treated within 24 hours but is not life-threatening. It is medical care you can safely postpone until you can call a physician. Examples of urgent care include fever, earache, cuts, sprains, and minor burns. In instances like these, call your physician first for instructions. If your physician determines your situation is a medical emergency, he or she will refer you directly to an emergency facility. If it is not a medical emergency, your physician will tell you how to treat the problem yourself or make an appointment to see you. Your physician or a covering physician should be available 24 hours a day, every day.

Contact your physician for after hours care or care that is required at night or on a weekend or holiday. Again, your physician will provide instructions on how to treat your problem.

Emergency Room

Each time the member uses the hospital emergency room, the member must pay a copayment. If the member is admitted within 24 hours, the copayment amount is waived. There may also be additional medical charges for out-of-network emergency rooms that may not be reimbursed in full.

Federal Government Hospitals

NJ DIRECT will pay for eligible charges in hospitals operated by the United States government (Veterans Administration) as if they were member hospitals, regardless of their location, for eligible charges for nonmilitary conditions.

NJ DIRECT will pay hospitals operated by the United States government for nonmilitary patients (i.e., patients other than military retirees and their dependents and dependents of active duty military personnel) for eligible charges only if:

- Services are for treatment on an emergency basis for accidental injury from an external cause; or
- Services are provided in a hospital located outside of the United States and Puerto Rico.

Gynecological Care and Examinations

Gynecological care and examinations are eligible. NJ DIRECT provides coverage for one routine gynecological examination per year which may include one routine Pap smear, when provided by a gynecologist.

Home Health Care

Home health care services and supplies are covered only if furnished by providers on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis. Precertification is required for these services.

The home health care plan must be established in writing by the member's provider within 14 days after home health care starts and it must be reviewed by the member's provider at least once every 30 days.

Eligible home health services (subject to exclusions) provided by a home health care agency include:

- Part-time skilled nursing services provided by or under the supervision of a registered professional nurse (R.N.).
- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Related treatment and services eligible for hospital benefits, except drugs and administration of hemodialysis.
- Medical social services or part-time services by a home health care aide during the period when you are receiving eligible skilled nursing care, physical therapy, or speech therapy services.

A prior inpatient hospital stay is not required to qualify for home health care agency benefits but the patient must be homebound and require skilled nursing care under a plan prescribed by an attending physician.

NJ DIRECT **does not** cover:

- Services furnished to family members, other than the patient.
- Services provided by a companion.
- Services and supplies not included in the home health care plan.
- Nursing home care or care that is **maintenance care**, supportive care, care to treat deficiencies that are developmental in nature or are primarily **custodial care** in nature.

Hemophilia Treatment

Hemophilia treatment is covered in an inpatient facility or outpatient facility. Home hemophilia treatment will be considered when there is documented medical evidence that these services cannot be performed in an outpatient facility.

Hospice Care Benefits

Benefits for hospice care must be provided according to a physician prescribed course of treatment approved by NJ DIRECT with a confirmed diagnosis of terminal illness and a life expectancy of six (6) months or less.

The following hospice services are covered:

- Part-time professional nursing services of an R.N. or L.P.N.
- Home health care aide services provided under the supervision of an R.N.
- Medical care rendered by a hospice care program physician.
- Therapy services (including speech, physical and occupational therapies).
- Diagnostic services.
- Medical and surgical supplies.
- Durable medical equipment.
- Prescribed drugs.
- Oxygen and its administration.
- Up to 10 days for respite care.
- Inpatient acute care for related conditions.
- Medical social services.
- Psychological support services to the terminally ill patient.
- Family counseling related to the Eligible Person's terminal condition.
- Dietician services.
- Inpatient room, board and general nursing services for related conditions.

No benefit consideration will be given for any of the following hospice care benefits:

- Medical care rendered by the patient's private physician (would be paid separately under the plan).
- Volunteer services.

- Pastoral services.
- Homemaker services.
- Food or home-delivered meals.
- Non-authorized private-duty nursing services.
- Dialysis treatment.
- Bereavement counseling.

Inpatient benefits for hospice patients are provided at the same level as those provided for non-hospice patients. For more information on hospice care, please call Horizon BCBSNJ at 1-800-414-7427.

Hospital-Based Weight Loss Programs

Hospital-based weight loss programs may be eligible for a patient diagnosed with morbid obesity. For in-network level benefits, the provider must obtain authorization from the plan. For out-of-network services, the member or provider should call Horizon BCBSNJ at 1-800-664-2583 to verify eligibility prior to enrolling in a hospital-based weight loss program.

Immunizations

Immunizations provided by an in-network physician are covered under NJ DIRECT unless they are for travel outside the country or work-related. Well-child immunizations for children less than 12 months of age are the only immunizations allowed out-of-network.

Infertility Treatment

NJ DIRECT will follow the New Jersey State Mandate for Infertility.

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

Eligibility Requirements

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

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

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

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

Covered Expenses

- Where a live donor is used in the egg retrieval, the medical costs of the donor shall be covered until the donor is released from treatment by the reproductive endocrinologist;
- Egg retrievals where the cost was not covered by any carrier shall not count in determining whether the four completed egg retrieval limit has been met;
- Intracytoplasmic sperm injections;
- In vitro fertilization, including in vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier or surrogate;
- Prescription medications, including injectable infertility medications, are covered under the SHBP/SEHBP's Prescription Drug Plans. Private freestanding prescription drug plans arranged by local employer groups are required to be comparable to the SHBP/SEHBP Prescription Drug Plans and must provide coverage for infertility medications for covered members and donors;
- Ovulation induction;
- Surgery, including microsurgical sperm aspiration;
- Artificial Insemination;
- Assisted Hatching;
- Diagnosis and diagnostic testing;
- Fresh and frozen embryo transfers.

Exclusions

The following are specifically ***excluded*** infertility services:

- Reversal of male and female voluntary sterilization;
- Infertility services when the infertility is caused by or related to voluntary sterilization;
- Non-medical costs of an egg or sperm donor. Medical costs of donors, including office visits, medications, laboratory and radiological procedures and retrieval, shall be covered until the donor is released from treatment by the reproductive endocrinologist;
- Cryopreservation of donor sperm, eggs and embryos;
- Any experimental, investigational or unproven infertility procedures or therapies;
- Payment for medical services rendered to a surrogate for purposes of childbearing where the surrogate is not covered by the carrier's policy or contract;

- Ovulation kits and sperm testing kits and supplies;
- In vitro fertilization, gamete intrafallopian tube transfer, and zygote intrafallopian tube transfer for persons who have not used all reasonable less expensive and medically appropriate treatments for infertility, who have exceeded the limit of four covered completed egg retrievals, or are 46 years of age or older.

Lead Poisoning Screening and Treatment

Lead poisoning screening (in-network only). Treatment is eligible In-Network and Out-of-Network.

Lithotripsy Centers

Lithotripsy services are covered when they are performed in an approved hospital or lithotripsy center. For information regarding the eligibility of certain centers, please call Horizon BCBSNJ at 1-800-414-7427.

Lyme Disease Intravenous Antibiotic Therapy

All intravenous antibiotic therapy for the treatment of Lyme Disease require precertification. When intravenous therapy is determined to be medically appropriate, the supplies, cost of the drug, and skilled nursing visits will be covered services. If services are not precertified and are determined not to be medically necessary, the services will not be covered.

Mammography

Covers mammograms provided to a female member. Coverage is provided as follows:

- One baseline mammography at any age.
- Age forty and older, one screening mammography per year.

Mastectomy Benefits

A hospital stay of at least 72 hours following a modified radical mastectomy and a hospital stay of at least 48 hours is covered following a simple mastectomy unless the patient, in consultation with his physician, determines that a shorter length of stay is medically needed and at the appropriate level of care.

Maternity/Obstetrical Care

Medical care related to childbirth includes the hospital delivery and hospital stay for at least 48 hours after a vaginal delivery or 96 hours after a cesarean section if the attending provider determines that inpatient care is medically needed and at the appropriate level of care.

Services and supplies provided by a hospital to a newborn child during the initial covered hospital stay of the mother and child is covered as part of the obstetrical care benefits.

NJ DIRECT also covers birthing center charges made by a provider for pre-natal care, delivery, and post-partum care in connection with a member's pregnancy.

Maternity/Obstetrical Care for Child Dependents

In some instances, NJ DIRECT will pay bills related to the birth of a grandchild. In order for benefits to be available, **all** of the following must apply:

- The mother must be enrolled as a dependent;
- The mother resides with the member and must be substantially dependent on the member for support and maintenance; and

- The mother is under the age of 23 and unmarried.

Coverage for the grandchild ends when the mother is discharged from the hospital. The grandparent may apply for coverage of the grandchild under the SHBP only if (s)he obtains legal custody of the child. The mother may apply for COBRA coverage for the newborn.

Mental or Nervous Conditions and Substance Abuse

Magellan Behavioral Health is responsible for the management of your behavioral health benefit. This benefit includes treatment for both mental health and alcohol/ substance abuse provided by an eligible behavioral health provider and include—in-patient, partial hospital, residential, intensive out-patient, out-patient and group treatment. Eligible providers of behavioral health are Psychiatrists (MD), Licensed Psychologists (PhD), Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), Licensed Professional Counselors (LPC), and Certified (Psychiatric), Nurse Practitioners working within the scope of their practice.

Your benefit may allow treatment for behavioral health alcohol and substance abuse however; precertification (prior to treatment) is required by Magellan Behavioral Health for all admissions (in-network and out-of-network). The Precertification process will determine if the treatment to be provided is medically appropriate and if it will be provided at the most appropriate level of care to fit your behavioral health needs. Magellan Behavioral Health medical necessity determinations for mental health services are supported by Magellan Medical Necessity criteria. Substance abuse determinations are supported by the American Society of Addictions Medicine (ASAM) guidelines. The precertification process through Magellan Behavioral Health is available 24 hours a day, 7 days a week. In addition to the precertification process, Magellan Behavioral Health will support your treatment and manage the services you are receiving to ensure that they are the most appropriate for your behavioral health needs and ensure that your treatment is supported by Magellan Behavioral Health Medical Necessity criteria and/or the American Society of Addictions Medicine (ASAM) criteria.

Out-Patient Behavioral Health Benefits

In-Network and out-of-network out-patient Mental Health services require precertification. If you are receiving services from an in-network provider, precertification will be requested by the network provider. Precertification for out-of-network services must be requested before the 8th visit. When additional sessions are needed, the out-of-network and in-network provider will be required to complete a Treatment Request Form (TRF) at least two weeks before the current certification visits expire. Your provider may complete the TRF online at: www.magellanhealth.com. Magellan Behavioral Health's online TRF application allows providers to request additional services through a secure website. If your provider requires a copy of a TRF, he/she may call 1-800-991-5579 to speak with a Magellan customer service associate. Once the TRF is received by Magellan Behavioral Health (either online or hard copy) it will be processed and the provider and member will receive a written Precertification determination by mail. If you do not obtain precertification, the amount that you are required to pay will not apply to the out-of-pocket maximums.

Nutritional Counseling (In-Network Only)

NJ DIRECT allows three visits per year for nutritional counseling that is medically needed and at the appropriate level of care.

Occupational Therapy (See Physical Therapy.)

Organ Transplant Benefits

Pre-approved services and supplies for the following types of transplants are covered:

- Lung.
- Liver.
- Heart.
- Pancreas.
- Certain autologous bone marrow.
- Cornea (pre-approval is not required in or out-of-network).
- Kidney (pre-approval is not required in or out-of-network).

Benefits only include surgical, storage and transportation services of the organ which are directly related to the donation and billed for by the hospital.

Pain Management

Pain management services are covered subject to medical guidelines. Pain management therapy must be supported by a comprehensive evaluation of the patient, the rationale for treatment must be well documented, and treatment must include a comprehensive program that is multifaceted and may include therapeutic exercises, activity modification, physical therapy, occupational therapy, pharmacological interventions, mental health and behavioral interventions, therapeutic and injection interventions, and surgical interventions, if needed. Treatment will not always achieve complete elimination of a patient's pain. In such cases, an increase in a patient's level of function and teaching the patient strategies to cope with residual pain will be the aim. If treatment reaches a point at which no appreciable improvement in the patient's condition is anticipated, services will be considered maintenance and/or supportive care and will not be eligible for reimbursement.

Pap Smears

Annual Pap smears provided by your participating OB/GYN are covered at the in-network level of benefits. This benefit is limited to one Pap smear per year unless additional tests are medically needed and at the appropriate level of care for diagnostic purposes. An annual Pap smear provided out-of-network is covered, subject to any deductible and coinsurance.

Patient Controlled Analgesia (PCA)

Patient Controlled Analgesia (PCA) is covered when it is medically appropriate, prescribed by a medical doctor, and provided under the guidance of one of the following:

- Doctor;
- Anesthesiologist; or
- Approved home care agency.

Physical Therapy/Occupational Therapy

Therapy that is medically needed and at the appropriate level of care is covered based on one session per day. A session of therapy is defined as up to one hour of therapy (treatment and/or evaluation) or up to three therapy modalities provided on any given day.

Physicals (In-Network Only)

Routine physical examination(s) for you and your eligible dependents are covered in-network only.

Physicals for work related purposes, sports, or other similar reasons are **not** covered.

Pre-Admission Hospital Review (In-Network and Out-of-Network)

All non-emergency hospital and other facility admissions must be reviewed by Horizon BCBSNJ before they occur. You or the network hospital or your provider must notify Horizon BCBSNJ and request a Pre-Admission Review by phone or facsimile. Horizon BCBSNJ must receive the notice and request at least 5 business days or as soon as reasonably possible before the admission is scheduled to occur. For a maternity admission, such notice must be given to Horizon BCBSNJ at least 60 days before the expected date of delivery, or as soon as reasonably possible, to obtain in-network benefits.

Pre-Admission Testing Charges

Pre-admission diagnostic X-ray and laboratory tests needed for a planned hospital admission or surgery are covered. NJ DIRECT only covers these tests if the tests are done on an outpatient or out-of-hospital basis within seven days of the planned admission or surgery.

However, NJ DIRECT does not cover tests that are repeated after admission or before surgery, unless the admission or surgery is deferred solely due to a change in the member's health.

Prostate Cancer Screening (In-Network Only)

One routine office visit per year is covered for adult members, including a digital rectal examination and a prostate-specific antigen test for adult male members over the age of 40.

Scalp Hair Protheses

A benefit maximum of **\$500** in a **24** month period, per person, is covered for scalp hair protheses prescribed by a doctor, only if they are furnished in connection with hair loss resulting from:

- Treatment of disease by radiation or chemicals;
- Alopecia Universalis (totalis); or
- Alopecia Areata.

Second Surgical Opinion

NJ DIRECT provides coverage for a second physician's personal examination of a patient following a recommendation for any eligible surgical procedure. NJ DIRECT will pay for one consultation by a qualified specialist physician.

If the second opinion specialist does not confirm the need for surgery, NJ DIRECT will provide coverage for one additional consultation if requested by the patient. NJ DIRECT also will provide coverage for any diagnostic X-rays, laboratory tests, or diagnostic surgical procedures required by the physicians performing the consultations.

Shock Therapy Benefits

NJ DIRECT provides benefits for electroshock treatments, insulin shock treatments, and other similar treatments. All treatment provided will be counted towards the annual and lifetime mental health visit maximums. Benefits are also payable for anesthesia in

connection with the shock treatment and for all other eligible services performed on that day for the disorder.

Skilled Nursing Facility Charges

Room and board, including diets, drugs, medicines and dressings, and general nursing services in a skilled nursing facility are covered.

Speech Therapy Benefit

Speech therapy services provided by a qualified speech therapist are covered only as follows:

- **To restore speech** after a loss of a demonstrated previous ability to speak or impairment of a demonstrated previous ability to speak.
- To develop or improve speech after surgery to correct a defect that existed at birth and impaired the ability to speak or would have impaired the ability to speak.

Speech therapy to correct pre-speech deficiencies or to improve speech skills that have not fully developed are not covered except for Autism and Pervasive Development Disorder (PDD).

Speech therapy services will be considered eligible for a period of one year for children with a documented medical history of multiple cases of Otitis Media and one or more myringotomy(ies).

Surgical Services (Out-of-Network)

- **Multiple Procedures**

If multiple procedures are performed during the same operative session, the procedure with the highest Relative Value Unit (RVU) will be considered the primary procedure and the full reasonable and customary allowance will be allowed for that primary procedure minus any applicable member deductible and coinsurance liability. The RVU associated with the procedure codes represents the time and skill involved in the performance of the procedure. All eligible additional procedures performed in the same operative session will be considered secondary procedures that are paid at 50 percent of the reasonable and customary allowance.

- **Bilateral Procedures**

Bilateral procedures will be paid at 150 percent of the reasonable and customary allowance. Services qualify as bilateral when anatomically there are two specific body parts which are being operated upon during the same surgery such as ears, eyes, knees, breasts, and kidneys. A lesion on the right arm and a lesion on the left arm would not qualify as bilateral since the skin is one body organ.

- **Reasonable and Customary Allowances (for Out-of-Network Services)**

The Plan covers only reasonable and customary allowances, which are determined by the Prevailing Healthcare Charges System (PHCS) fee schedule. This schedule is based on actual charges by physicians in a specific geographic area for a specific service. If your physician charges more than the reasonable and customary allowance, you will be responsible for the full amount above the reasonable and

customary allowance in addition to any deductible and coinsurance you may be required to pay.

Temporomandibular Joint Disorder (TMJ) and Mouth Conditions

Medical and surgical services performed for the treatment of the jaw are covered. Services in relation to the teeth in any manner are excluded. Charges for doctor's services or X-ray examinations for a **mouth condition** are not eligible.

Charges for dental or orthodontic services for a TMJ diagnosis are not eligible. This exclusion applies even if a condition requiring any of these services involves a part of the body other than the mouth, such as treatment of TMJ or malocclusion involving joints or muscles by methods including but not limited to crowning, wiring or repositioning of teeth and dental implants.

Vision Care Benefits

NJ DIRECT covers an annual eye examination by an in-network ophthalmologist or optometrist. There are no benefits available for frames, lenses, or contact lenses. There is no out-of-network preventive vision care benefit.

Any visits to an ophthalmologist or optometrist for the diagnosis and treatment of a condition will be eligible at the in-network and out-of-network level of benefits.

CHARGES NOT COVERED BY NJ DIRECT

Even though a service or supply may not be described or listed in this handbook, that **does not** make the service or supply eligible for a benefit under this plan.

The following services and supplies **are not covered**:

- Automobile accident-related injuries or conditions: Unless NJ DIRECT has been chosen by the member as primary, NJ DIRECT does not pay for the treatment of injuries or conditions related to an automobile accident if automobile insurance could have or should have covered the treatment. This exclusion applies to, but is not limited to:
 - ✓ Existing motor vehicle insurance contracts;
 - ✓ Motor vehicle contracts that were purchased but have since lapsed;
 - ✓ Motor vehicle insurance coverage that should have been purchased; and
 - ✓ Failure to make timely claims under a motor vehicle insurance policy.
- Autopsy.
- Car Seats.
- Care that is primarily custodial in nature.
- Chair and stair lifts.
- Charges above the reasonable and customary allowance.
- Charges billed by an Assisted Living Facility.
- Charges for services or supplies not specifically covered under the plan.
- Charges for services rendered by a member of the patient's immediate family (including you, your spouse/domestic partner, your child, brother, sister, or parent of you or your spouse/domestic partner).
- Charges for the completion of a claim form, photocopies of pertinent medical information, or medical records.
- Charges in connection with an external review of an appeal or complaint.
- Charges incurred prior to or in the course of a legal adoption.
- Charges that should have been paid by Medicare, if Medicare coverage had been in effect.
- Cosmetic procedures — charges connected with curing a condition by cosmetic procedures. This provision does not apply if the condition is due to an accidental injury that occurred while the injured person is enrolled in NJ DIRECT. Among the services that are not covered are:
 - ✓ Removal of warts, with the exception of plantar warts;
 - ✓ Spider vein treatment; and
 - ✓ Plastic surgery when performed primarily to improve the person's appearance.
- Costs beyond the embryo transfer for a surrogate are not eligible.
- Court ordered services or treatments.
- Custom-molded shoes, regardless of diagnosis.

- Deluxe models of wheelchairs and other durable medical equipment.
- Dental Care – other than accidental injury.
- Durable medical equipment or supplies which are specifically excluded from coverage. To determine which equipment or supplies are eligible for coverage, call 1-800-414-SHBP (7427).
- Educational or developmental services or supplies, or educational testing. This includes services or supplies that are rendered with the primary purpose being to provide the person with any of the following:
 - ✓ Training in the activities of daily living. This does not include training directly related to the treatment of an illness or injury that resulted in a loss of a previously demonstrated ability to perform those activities.
 - ✓ Instruction in scholastic skills such as reading and writing.
 - ✓ Preparation for an occupation.
 - ✓ Treatment for learning disabilities.
 - ✓ To promote development beyond any level of function previously demonstrated.
 - ✓ Assessments/testing of academic function.
 - ✓ Services and supplies are not covered to the extent that they are determined to be allocated to the scholastic education or vocational training of the patient regardless of where services are rendered. Rehabilitation programs that are primarily educational or behavioral in nature.
- Expenses for wilderness rehabilitation programs, diabetic camps, or other similar camps or programs.
- Experimental or investigational services or supplies and charges in connection with such services or supplies (see page 14).
- Eye care including:
 - ✓ Out-of-network examinations to determine the need for glasses or lenses of any type, typically known as refraction examinations regardless of the diagnosis.
 - ✓ Lenses of any type except initial lens replacement for loss of the natural lens after cataract surgery.
 - ✓ Eyeglasses and contact lenses regardless of the diagnosis, including but not limited to Kerataconus.
 - ✓ Low vision aids.
 - ✓ Eye surgery, such as radial keratotomy, Lasik procedures, or other refractive procedures performed for any reason.
- Foot conditions — charges for doctor's services for:
 - ✓ A weak, strained, flat, unstable, or imbalanced foot, metatarsalgia, or a bunion. However, this exclusion does not apply to an open cutting operation.
 - ✓ One or more corns, calluses, or toenails. This exclusion does not apply to a charge for the removal of part or all of a nail root and services connected with treating metabolic or peripheral vascular disease.

- Government plan charges including a charge for a service or supplies:
 - ✓ Furnished by or for the United States government;
 - ✓ Furnished by or for any government, unless payment is required by law; or
 - ✓ To the extent that the service or supply, or any benefit for the charge, is provided by any law or government plan under which the member is or could be covered. This applies to Medicare and "no-fault" medical and dental coverage when required in contracts by a motor vehicle law or similar law.
- Hearing aids of any type.
- Hearing examinations to determine the need for hearing aids or the need to adjust a hearing aid, no matter what the cause of the hearing loss.
- Herbal, Alternative or Complementary medicine treatments.
- Hot tubs, saunas, Jacuzzis or pools of any type.
- Hypnosis.
- Immunizations and preventive vaccines when out-of-network (see exceptions under "Immunizations" on page 27).
- Legal fees.
- Maintenance care — care that has reached a level where additional services will not appreciably improve the condition.
- Marriage counseling.
- Modifications to an auto to make it accessible and/or drivable.
- Modifications to a home to make it accessible for a disabled/injured person.
- Mouth conditions — charges for doctor's services or X-ray examinations for a mouth condition. This exclusion applies even if a condition requiring any of these services involves a part of the body other than the mouth, such as treatment of Temporomandibular Joint disorders (TMJ) or malocclusion involving joints or muscles by methods including, but not limited to, crowning, wiring, or repositioning of teeth. See page 66 of the "Glossary" for the definition of a mouth condition.
- Nursing home care.
- Over-the-counter supplies, supplements, vitamins, medications, or drugs that do not require a prescription order under Federal law, even if the prescription is written by a physician. These include, but are not limited to, aspirin, vitamins, lotions, creams, oils, formulas, liquid diets, and dietary supplements.
- Personal comfort or convenience items including telephone or television service, haircuts, guest trays, or a private room during an inpatient stay.
- Prescription drug charges or copayments, unless your SHBP participating employer does not provide prescription drug coverage. If your non-SHBP prescription drug plan does not provide benefits for a particular drug, it does not mean that it will be eligible under NJ DIRECT benefits.
- Private Duty Nursing (Inpatient).
- Postage, handling and shipping fees.

- Private rooms in a hospital. If you occupy a private room in a hospital or facility, you must pay the difference between the private room rate and the average semiprivate room rate.
- Preventive care/routine screening — unless otherwise indicated, NJ DIRECT's out-of-network coverage does not provide benefits for services or supplies that are considered to be performed for any of the following:
 - ✓ Routine well-care as part of a routine examination.
 - ✓ Services and supplies that are provided for a diagnosis that does not indicate an illness present at the time the service are rendered.
 - ✓ Services that are considered preventive or screening in nature.

The following services are examples of out-of-network routine services that are **not** covered:

- ✓ All immunizations/vaccinations including well-child immunizations/vaccinations (except for children under 12 months of age).
 - ✓ Flu shots/pneumonia vaccines.
 - ✓ Well-care annual physicals.
 - ✓ Cancer antigen tests that are performed because of a family history. Specific guidelines apply to the eligibility of cancer antigen tests. Therefore, you may wish to request a pre-determination of benefits prior to having services rendered.
 - ✓ PSA (Prostate Specific Antigen) as part of a routine examination or recommended due to a family history of disease. Specific guidelines apply to the eligibility of PSA for non-routine reasons.
- Self- or home-testing kits whether prescribed by a doctor or not.
 - Services or supplies that are not medically needed and/or not at the appropriate level of care and charges in connection with such services or supplies. The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, in itself, make it medically needed for the treatment and diagnosis of an illness or injury or make it a covered medical expense.
 - Services that are commonly or customarily provided without charge to the patient. Even when the services are billed, NJ DIRECT will not pay if they are usually not billed when there is no coverage available.
 - Services and supplies prescribed or provided by an ineligible provider.
 - Services rendered before the effective date of coverage or after the termination of coverage date. However if the covered patient is hospitalized as an inpatient and coverage terminates during the stay, that inpatient stay (as long as otherwise eligible) will be covered through to discharge.
 - Services rendered by providers who are not registered with or who opt-out of Medicare.
 - Services rendered or billed by an Assisted Living Facility.
 - Speech therapy to correct pre-speech deficiencies or to improve speech skills that have not fully developed (Exceptions: Autism and Pervasive Developmental Disorder).

- Sports physicals.
- Supportive care — supportive care is defined as treatment for patients having reached maximum therapeutic benefit in whom periodic trials of therapeutic withdrawals fail to sustain previous therapeutic gains. In some instances therapy may be clinically appropriate (such as treatment of a chronic condition that requires supportive care) yet it would not be eligible for reimbursement under NJ DIRECT.
- Taxes on services/supplies.
- Telephone consultations or provider charges for telephone calls.
- Transport — Non-emergency transport via ambulance or transport by coach of any kind (by land, air, or water).
- Treatment of injuries sustained while committing a felony.
- War — charges for illness or injury due to an act of war. War means either declared or undeclared, including resistance or armed aggression.
- Work-related injury or disease. This includes the following:
 - ✓ Injuries arising out of or in the course of work for wage or profit, whether or not you are covered by a Workers' Compensation policy.
 - ✓ Disease caused by reason of its relation to Workers' Compensation law, occupational disease laws, or similar laws.
 - ✓ Work-related tests, examinations, or immunizations of any kind required by your work.
 - ✓ Work related injuries will not be eligible for benefits under NJ DIRECT before or after your Worker's Compensation carrier has settled or closed your case.

Please note: If you collect benefits for the same injury or disease from both Workers' Compensation and NJ DIRECT, you may be subject to prosecution for insurance fraud.

Examples of Non-Covered Services:

Example 1: A physician orders inpatient private duty nursing for a surgery patient. Since, while confined in a hospital, nursing services are provided by the hospital, any charges for private duty nursing will not be paid.

Example 2: A person is studying to become a therapist and is required by the school to enter therapy. The treatment is intended to ensure that the new therapist is well-equipped to work with patients. The treatment is not covered because it is primarily educational.

Example 3: A physician orders a drug that is FDA-approved but is not commonly used to treat the particular condition. If NJ DIRECT determines that the use is experimental, the plan will not pay for the drug.

Example 4: A hospital routinely requires an assistant surgeon or Registered Nurse First Assistant (RNFA) to be present at certain operations. Other hospitals do not have that requirement. NJ DIRECT will not pay for assistant surgeons/RNFAs that are determined to be not medically necessary. Only in-network RNFAs are eligible.

THIRD PARTY LIABILITY

Repayment Agreement

If you have received benefits from NJ DIRECT for medical services that are either auto-related or work-related, Horizon BCBSNJ has the right to recover those payments. This means that if your medical expenses are reimbursed through a settlement, satisfied by a judgment, or other means, you are required to return any benefits paid for illness or injury to NJ DIRECT. The repayment will only be equal to the amount paid by NJ DIRECT.

This provision is binding whether the payment received from the third party is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, whether or not the third party has admitted liability for the payment.

Recovery Right

You are required to cooperate with Horizon BCBSNJ in recovering any amounts payable. Horizon BCBSNJ may:

- Assume your right to receive payment for benefits from the third party;
- Require you to provide all information and sign and return all documents necessary to exercise NJ DIRECT's rights under this provision, before any benefits are provided under your group's policy;
- Require you to give testimony, answer interrogatories, attend depositions, and comply with all legal actions which Horizon BCBSNJ may find necessary to recover money from all sources when a third party may be responsible for damages or injuries.

SUBROGATION AND REIMBURSEMENT

Benefits payable as a result of any injuries claimed against any person or entity other than this Health Plan are excluded from coverage under this Plan. If benefits are provided by this Plan that are otherwise payable or become payable by any third party action against any person or entity, this Plan is entitled to reimbursement only on the following terms and conditions:

1. In the event that benefits are provided under this Plan, the Plan shall be subrogated to all of the Member's (the term Member includes any person receiving benefits hereunder including all dependents) rights of recovery against any person or organization to the extent of the benefits provided. The Member shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The Member shall do nothing after loss to prejudice such rights. The Member must cooperate with the Plan and/or any representatives of the Plan in completing such forms and in giving such information surrounding any accident as the Plan or its representatives deem necessary to fully investigate the incident.
2. The Plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with, and not exclusive of, the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the Plan.
3. The subrogation and reimbursement rights and liens apply to any recoveries made by the Member as a result of the injuries sustained, including but not limited to the following:

- a. Payments made directly by a third party, or any insurance company on behalf of a third party, or any other payments on behalf of the third party ..
 - b. Any payments or settlements, judgment or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of a Member or other person.
 - c. Any other payments from any source designed or intended to compensate a Member for injuries sustained as the result of negligence or alleged negligence of a third party.
 - d. Any worker's compensation award or settlement.
 - e. Any recovery made pursuant to no-fault insurance.
 - f. Any medical payments made as a result of such coverage in any automobile or homeowners insurance policy.
4. The Plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Member, whether under comparative negligence or otherwise.

WHEN YOU HAVE A CLAIM

Submitting a Claim (In-Network)

Generally you will not have to submit any claim forms to Horizon BCBSNJ for reimbursement for treatment from a network provider. You will simply pay the provider the required copayment amount and the provider will submit claims directly to Horizon BCBSNJ for the appropriate reimbursement.

Submitting a Claim (Out-of-Network)

If you receive treatment out-of-network, claims must be submitted for reimbursement to:

**Horizon BCBSNJ,
P.O. Box 820,
Newark NJ 07101-0820
(Phone: 1-800-414-SHBP).**

All mental health and substance abuse claims should be mailed to:

**Magellan/NJ DIRECT
P.O. Box 5172,
Columbia, MD 21045-5172**

Filing Deadline (Proof of Loss)

Horizon BCBSNJ must be given written proof of a loss for which a claim is made under NJ DIRECT. This proof must cover the occurrence, character, and extent of the loss. It must be furnished **within one year and 90 days of the end of the calendar year in which the services were incurred.** For example, if a service were incurred in the year 2008, you would have until March 31, 2010, to file the claim.

A claim will not be considered valid unless proof is furnished within the time limit shown 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 medical expenses. The itemized bills must include the following:

- Name and address of provider;
- Provider's tax identification number;
- Name of patient;
- Date of service;
- Diagnosis;
- Type of service;
- CPT 4 code; and
- Charge for each service.

Foreign Claims

Bills for services that are incurred outside of the United States must include an English translation and the charge for each service performed. The exchange rate at the time of service should also be indicated on the bill that is submitted for reimbursement.

Filling Out the Claim Form

Be sure to fill out the claim form completely. Include the identification number that appears on your NJ DIRECT identification card. Fill out all applicable portions of the claim form and sign it. A separate claim form must be submitted for each individual and each time you file a claim.

MEDICARE CLAIM SUBMISSION

If a member is a New Jersey resident, has Medicare primary coverage, and receives care within New Jersey, claims will be transmitted automatically from the Medicare carrier to NJ DIRECT.

If a member resides in another state and has Medicare primary coverage, the member will have to submit a copy of the *Medicare Explanation of Benefits*, an itemized bill, and a completed NJ DIRECT claim form to Horizon BCBSNJ

AUTHORIZATION TO PAY PROVIDER

The providers that participate with NJ DIRECT will be paid directly for eligible services. The member will be paid for all services rendered by non-participating providers. Once payment has been made to the member for services rendered, Horizon BCBSNJ will not have to pay the benefit again.

QUESTIONS ABOUT CLAIMS

If you have questions about a hospital claim, hospital benefits, a medical claim, or medical benefits or if you need a claim form, call Horizon BCBSNJ at 1-800-414-SHBP (7427).

If for any reason the claim is not eligible, you will be notified of its ineligibility within 90 days of receipt of your claim. To request a review of the claim, you should follow the instructions described in the "Appeal Procedures" section.

APPEAL PROCEDURES

UTILIZATION REVIEW APPEAL

If you are not satisfied with any utilization review decision, including but not limited to hospitalization admission denials or a reduction of benefits payable, you or your provider may appeal such decision by writing to Horizon BCBSNJ. A nurse reviewer will collect any additional medical information required and submit the case to a Horizon BCBSNJ Medical Director for review. The Medical Director will review the case with the reviewer who made the initial decision. The Medical Director may discuss the case with your provider. You and your provider will be notified of the appeal recommendation.

You (or a provider acting on your behalf and with your consent) may appeal any administrative and utilization management determinations made by Horizon BCBSNJ with respect to its coverage. These determinations involve benefit issues — including denials, terminations, or other limitations of covered services and supplies.

CLAIMS APPEAL

First Level Appeal

You initiate the appeal process by calling Horizon BCBSNJ at 1-800-414-SHBP (7427) to begin your verbal appeal or to receive instructions on how to submit a written appeal. All First Level Appeals must be made within 12 months of the date you were notified of the original determination.

A provider initiates an appeal by calling or writing to the Horizon BCBSNJ services representative or Utilization Department. All pertinent information will be reviewed by a Horizon BCBSNJ Medical Director and a decision will be made on the appeal.

A First Level Appeal may be submitted in writing or may be initiated verbally. If the appeal is submitted in writing, it must be dated and signed, with the following information:

- Name(s) and address(es) of the member(s) and providers involved;
- The member's NJ DIRECT identification number;
- Date(s) of service;
- Details regarding the actions in question;
- The nature of the service and reason behind the appeal;
- The remedy sought; and
- All documentation to support the appeal.

Second Level Appeal

If either you or your provider is not satisfied with the determination made on your First Level Appeal, you can file a Second Level Appeal before other health care professionals selected by Horizon BCBSNJ who were not involved in the initial determination. You or your provider will receive notification of the final determination of the Second Level Appeal, the reasons therefore and instructions for filing an external appeal.

Commission Appeal

If you are dissatisfied with the results of Horizon BCBSNJ's internal appeal process, you or your legal representative can appeal in writing to the State Health Benefits Commission. The right to such an appeal is contingent upon full compliance with both stages of the Horizon BCBSNJ internal appeal process.

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

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

- Name(s) and address(es) of patient and employee;
- Employee's NJ DIRECT 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 Horizon BCBSNJ decision on a medical appeal, only the member or the member's legal representative (this does not include the provider of service) may appeal, in writing, to the Health Benefits Commission. If the member is deceased or incapacitated, the individual legally entrusted with his or her affairs may act on the member's behalf. Request for consideration must contain the reason for the disagreement along with copies of all relevant correspondence and should be directed to the following address:

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

Notification of all Commission decisions will be made in writing to the member. If the Commission approves the member's appeal, the decision is binding upon Horizon BCBSNJ. 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 that the case be forwarded to the Office of Administrative Law. Written request to the Commission must be received within 45 days. 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 may be made to the Superior Court of New Jersey, Appellate Division.

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

PRESCRIPTION DRUG BENEFITS

The State Health Benefits Commission requires that all covered employees and retirees have access to prescription drug coverage.

EMPLOYEE PRESCRIPTION DRUG PLAN

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

The Employee Prescription Drug Plan is currently administered by Horizon BCBSNJ through Caremark.

Plan Benefits

Employee Prescription Drug Plan benefits are available through a **participating retail pharmacy** or through the Caremark **mail order** and **specialty pharmacy services**.

- **Retail pharmacy** services require a copayment for each 30-day supply. Employee Prescription Drug Plan participants may obtain up to a 90-day supply of prescription drugs at participating retail pharmacies. You are required to pay two copayments for a 31 to 60-day supply or three copayments for a 61 to 90-day supply.
- **Mail order** participants can receive up to a 90-day supply of prescription drugs for one mail order copayment.
- **Specialty pharmacy services** are provided through Caremark Specialty Pharmacy which is the exclusive provider for specialty pharmaceuticals for the SHBP's prescription drug plans. Specialty pharmaceuticals are a class of medications that are typically produced through biotechnology, administered by injection, and/or require special patient monitoring and handling. If your doctor has prescribed a specialty pharmaceutical, you will not be able to fill the prescription at a retail pharmacy. If you try to fill a specialty prescription at a retail pharmacy, the pharmacy representative will advise you to contact CaremarkConnect at 1-800-237-2767. When calling, identify yourself as a State Health Benefits Program member. Caremark will contact your doctor and take care of the appropriate paperwork. Your medication will be shipped directly to your home, office, or doctor's office.

For more information about the Employee Prescription Drug Plan, copayment amounts, and specific benefits, see the [Employee Prescription Drug Plan Member Handbook](#) which is available from your employer, from the Division of Pensions and Benefits, or at the SHBP home page at: www.state.nj.us/treasury/pensions/shbp.htm

Prescription Drug Benefits Provided Through NJ DIRECT

- **If you are employed by a county, municipality, board of education, or other local public employer that does not provide a separate prescription drug plan, NJ DIRECT will include prescription drug benefits.**

- **If you are eligible for prescription drug coverage through a separate drug plan provided by your employer**, NJ DIRECT will not include prescription drug coverage and any prescription drug expenses from other group plans will not be reimbursed through NJ DIRECT.

Active employees whose employer does not offer a separate prescription drug plan have prescription drug coverage through the Employee Prescription Drug Reimbursement Plan for NJ DIRECT. The Employee Prescription Drug Reimbursement Plan is accepted at most pharmacies nationwide. These pharmacies have agreed to provide prescription drugs at a discounted price to plan members. When you use a participating pharmacy, most claims can be submitted electronically to the plan for consideration.

Prescriptions will be reimbursed at 90 percent of the allowed amount.

After your NJ DIRECT out-of-pocket maximum has been reached (see “Coinsurance” on page 17), you will be reimbursed 100 percent of the eligible pharmacy price under the Employee Prescription Drug Reimbursement Plan.

Mail order service is available through the Employee Prescription Drug Reimbursement Plan for NJ DIRECT for active employees (including COBRA participants) who do not have a separate prescription drug plan through their employer. The mail order service is administered by Horizon BCBSNJ through Caremark. Members may order maintenance prescriptions by mail or online from caremark.com, the mail service pharmacy owned and operated by Caremark.

Specialty pharmacy services also apply — for details see “Specialty Pharmacy Services” on page 46.

Using a pharmacy that does not participate in the plan may result in higher out-of-pocket costs. If you have a prescription filled at a non-participating pharmacy or forget to present your Employee Prescription Drug Reimbursement Plan identification card, you will need to submit a completed claim for reimbursement.

Some prescription drugs are covered by the Employee Prescription Drug Reimbursement Plan only in certain quantities.

RETIREE PRESCRIPTION DRUG COVERAGE

Retirees enrolled in NJ DIRECT have access to a separate Retiree Prescription Drug Plan that includes retail pharmacy and mail order service. NJ DIRECT features a three-tiered design.

The copayment amounts— effective January 1, 2008 — for a 30-day supply are set at \$9 for generic drugs (Tier I), \$18 for preferred brand name drugs (Tier II), and \$36 for all other brand name drugs (Tier III) when purchased at a participating retail pharmacy. You may purchase up to a 90-day supply of medication at a pharmacy when prescribed by your provider, by paying the applicable copayments (31- to 60-day supply — two copayments, 61- to 90-day supply — three copayments).

Mail order copayments for up to a 90-day supply are \$9 for generic drugs, \$27 for preferred brand name drugs, and \$45 for all other brand name drugs.

Specialty pharmacy services also apply — for details see the definition of “Specialty Pharmacy Services” on page 46.

Effective January 1, 2008, there is a \$1,092 annual maximum in prescription drug copayments per person. Once a person has paid \$1,092 in copayments, that person is no

longer required to pay any prescription drug copayments for the remainder of the calendar year.

Note: The copayment and plan maximum amounts listed above may change each year based upon a “set cost sharing formula” that is a part of the plan design.

A majority of pharmacies participate with Caremark, however, some do not have agreements with Caremark and are not a part of the Retiree Prescription Drug Plan. When using a nonparticipating pharmacy, you will be asked to pay the full cost of the prescription drug to the pharmacist and file a claim with Caremark for reimbursement. The reimbursement will be based on the participating pharmacy allowance rather than the actual charge(s) paid.

Some prescription drugs are covered by the Retiree Prescription Drug Plan only in certain quantities.

Medicare Part D

Most Medicare eligible retirees and/or their Medicare eligible dependents need not enroll in Medicare Part D prescription drug coverage. Some SHBP members who qualify for low income subsidy programs may find it beneficial to enroll in Medicare Part D. However, once you and/or your dependents enroll in Medicare Part D, your SHBP retired group prescription drug benefits will be terminated for both you and your dependents.

COBRA COVERAGE

CONTINUING COVERAGE WHEN IT WOULD NORMALLY END

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that gives employees and their eligible dependents the opportunity to remain in their employer's group coverage when they would otherwise lose coverage. COBRA coverage is available for limited time periods (see "Duration of COBRA Coverage" on page 50), and the member must pay the full cost of the coverage plus an administrative fee.

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

COBRA enrollees have the same rights to coverage at Open Enrollment as are available to active employees. This means that you or a dependent who elected to enroll under COBRA are able to enroll in any SHBP health plan and, if offered by your employer, SHBP prescription drug coverage during the SHBP Open Enrollment period regardless of whether you elected to enroll for the coverage when you first enrolled in COBRA. However, any time of non-participation in the benefit is counted toward your maximum COBRA coverage period. If the Health Benefits Commission makes changes to the program available to active employees and retirees, those changes apply equally to COBRA participants.

COBRA Events

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

- Termination of employment (except for gross misconduct).
- Death of the member/retiree.
- Reduction in work hours.
- Leave of absence.
- Divorce, legal separation, dissolution of a civil union or domestic partnership (makes spouse/ partner ineligible for further dependent coverage).
- Loss of a dependent child's eligibility through independence (moving out of household), the attainment of age 23, marriage, civil union or domestic partnership.
- The employee elects Medicare as primary coverage. (Federal law requires active employees to terminate their employer's health coverage if they want Medicare as their primary coverage.)

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

Cost of COBRA Coverage

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

Duration of COBRA Coverage

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

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

COBRA coverage may be purchased by a dependent for up to 36 months if he or she becomes eligible because of your **death, divorce, dissolution of a civil union or domestic partnership**, or he or she becomes ineligible for continued group coverage because of **marriage, entering into a civil union or domestic partnership, attaining age 23, or moving out of the household**, or because you **elected Medicare as your primary coverage.**

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

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

Employer Responsibilities Under COBRA

The COBRA law requires employers to:

- Notify you and your dependents of the COBRA provisions within 90 days of when you and your dependents are first enrolled;
- Notify you and your dependents of the right to purchase continued coverage within 14 days of receiving notice that there has been a COBRA qualifying event that causes a loss of coverage;
- Send the COBRA Notification Letter and a COBRA Application within 14 days of receiving notice that a COBRA qualifying event has occurred;
- Notify the SHBP within 30 days of the loss of an employee's coverage; and
- Maintain records documenting their compliance with the COBRA law.

Employee Responsibilities Under COBRA

The law requires that you and/or your dependents:

- You or your eligible dependents must notify your employer (if you are retired, you must notify the Division of Pensions and Benefits' Health Benefits Bureau) that a divorce, legal separation, dissolution of a civil union or domestic partnership, or your death has occurred or that your child has married, entered into a civil union or domestic partnership, moved out of your household, or reached age 23 — notification must be given within 60 days of the date the event occurred;
- File a COBRA Application (obtained from your employer or the Health Benefits Bureau) within 60 days of the loss of coverage or the date of the COBRA Notice provided by your employer, whichever is later;
- Pay the required monthly premiums in a timely manner; and
- Pay premiums, when billed, retroactive to the date of group coverage termination.

Failure to Elect COBRA Coverage

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

- First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. The election of continuation of coverage under COBRA may help you to bridge such a gap. (If, after enrolling in COBRA you obtain new coverage which has a pre-existing condition clause, you may continue your COBRA enrollment to cover the condition excluded by the pre-existing condition clause.)
- Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition exclusions if you do not continue coverage under COBRA for the maximum time available to you.
- Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days of the date your group coverage ends. You will also have the same special enrollment right at the end of the COBRA coverage period if you get the continuation of coverage under COBRA for the maximum time available to you.

Termination of COBRA Coverage

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

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

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

APPENDIX I

SPECIAL PLAN PROVISIONS UNDER NJ DIRECT

WORK-RELATED INJURY OR DISEASE

Work-related injuries or disease are not covered under NJ DIRECT. This includes the following:

- Injuries arising out of or in the course of work for wage or profit, whether or not your injuries are covered by a Workers' Compensation policy.
- Disease caused by reason of its relation to Workers' Compensation law, occupational disease laws, or similar laws.
- Work-related tests, examinations, or immunizations of any kind required by your work.
- Work related injuries will not be eligible for benefits under your medical plan before or after your Worker's Compensation carrier has settled or closed your case.

Please note: If you collect benefits for the same injury or disease from both Workers' Compensation and NJ DIRECT, you may be subject to prosecution for insurance fraud.

MEDICAL PLAN EXTENSION OF BENEFITS

If you or a dependent are disabled with a condition or illness at the time of your termination from the SHBP, you may qualify for an extension of benefits for this specific condition or illness. You do not qualify for an extension of benefits if you currently have or are eligible for any other type of medical coverage including but not limited to Medicare. If you feel that you may qualify for an extension of benefits please contact Horizon BCBSNJ 1-800-414-SHBP (7427) for assistance.

If the extension applies, it is only for eligible expenses relating to the disabling condition or illness. An extension under NJ DIRECT will be for the time you or your dependent remains disabled from any such condition or illness, but not beyond the end of the calendar year after the one in which your coverage ends. During an extension there will be no automatic restoration of part or all of a lifetime benefit maximum.

AUDIT OF DEPENDENT COVERAGE

Periodically, the SHBP performs an audit using a random sample of members to determine if enrolled dependents are eligible under SHBP provisions. Proof of dependency such as a marriage certificate or birth certificate is required. Coverage for ineligible dependents will be terminated and could result in the payment of ineligible medical and/or prescription drug claims by the covered employee. Failure to respond to the audit will result in the termination of coverage for dependents.

TERMINATION FOR CAUSE

If any of the following conditions exist, you may receive written notice that you will no longer be covered under NJ DIRECT.

- If, after reasonable efforts, NJ DIRECT and/or participating providers are unable to establish and maintain a satisfactory, provider/patient relationship with you or you repeatedly act in a manner which is verbally or physically abusive.
- If you permit any person who is not authorized to use the identification card(s) issued to you. You may be liable for the cost of any claims paid for services for an ineligible individual.
- If you willfully furnish incorrect or incomplete information in a statement made for the purpose of effecting coverage.
- If you abuse the system, including, but not limited to theft, damage to a participating providers' property, or forgery of prescriptions.

Any action by NJ DIRECT under these provisions is subject to review in accordance with the established appeals procedures. If an appeal is denied and the decision upheld, this action is subject to appeal to the State Health Benefits Commission. No benefits, other than for emergencies, will be provided to the member and to any family members under the coverage as of 31 days after such written notice is given by NJ DIRECT.

If the State Health Benefits Commission overrules the decision to terminate, benefits will be restored.

APPENDIX II

SUMMARY SCHEDULE OF SERVICES AND SUPPLIES

New Jersey statutes, administrative code, and agreements between the SHBP and Horizon BCBSNJ govern this plan. The following schedule of benefits is a summary description of plan benefits and is not a complete listing. It does not describe all the limitations or conditions associated with the coverage as described in other sections of this handbook. All pertinent parts of this handbook should be consulted regarding a specific benefit. Health decisions should not be made on the basis of the information provided in this schedule. Horizon BCBSNJ will administer the coverage listed in this Schedule of Covered Services and Supplies, subject to the terms, conditions, limitations, and exclusions stated within this handbook.

Please note: The fact that a doctor may prescribe, order, recommend, or approve a service or supply does not, in itself, make it medically needed for the treatment and/or diagnosis of an illness or injury or make it a covered medical expense. Certain services are subject to precertification.

ELIGIBLE SERVICES AND SUPPLIES

In-Network: Copayments apply to the service unless otherwise indicated; **\$15 in NJ DIRECT15** and **\$10 in NJ DIRECT10**.

Out-of-Network: Deductibles apply to the service (up to annual maximums) before any reimbursement is paid. (Benefits for local education employees may be different. See the [SHBP Plan Comparison Summary](#) for specific benefit differences.)

Where indicated under Out-of-Network services, the reimbursement is **70 percent in NJ DIRECT15** and **80 percent in NJ DIRECT10**.

COVERED SERVICES

Acupuncture for Pain Management Only

In-Network **100 percent** coverage

Out-of-Network **70/80 percent** of the reasonable and customary allowance

Inpatient Alcohol or Substance Abuse

In-Network **100 percent** coverage

Out-of-Network **70/80 percent** of the reasonable and customary allowance,
subject to \$200 hospital deductible on most plans
(Not on the educator plan.)

Outpatient Alcohol or Substance Abuse

In-Network **100 percent** coverage (no copayment)

Out-of-Network **70/80 percent** of the reasonable and customary allowance

Allergy Testing

In-Network **100 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Ambulance Services

In-Network **90 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Ambulatory Surgery

In-Network **100 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Anesthesia

In-Network **100 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Biofeedback for General Conditions

In-Network **100 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Biofeedback for Non-Biologically-Based Mental Illnesses

In-Network *Inpatient: 100 percent* up to 25 days per calendar year;
balance at **90 percent**
Outpatient: 90 percent of reasonable and customary allowance
up to annual and/or lifetime maximum
Out-of-Network *Inpatient: 50 days* per calendar year at **50 percent** after
deductible; up to annual and/or lifetime maximums
Outpatient: 70/80 percent of the reasonable and customary allowance
up to the annual and lifetime mental health maximums

Chiropractic Services (No Referral Required)

In-Network and Out-of-Network is one combined 30 visit maximum.

In-Network **100 percent** coverage for maximum of 30 visits per calendar year
Out-of-Network **70/80 percent** of the reasonable and customary allowance
for maximum of 30 visits per calendar year

Diagnostic Laboratory

In-Network **100 percent** coverage (no copayment)
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Diagnostic X-Ray

In-Network **100 percent** coverage (no copayment)
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Dialysis Center Charges

In-Network **100 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Durable Medical Equipment

In-Network **90 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Emergency Room

In-Network **100 percent** coverage, after copayment*
(copayment is \$50 for NJ DIRECT15 and \$25 for NJ DIRECT10)
Out-of-Network** **100 percent** coverage, after copayment*
(copayment is \$50 for NJ DIRECT15 and \$25 for NJ DIRECT10)

**For both In-Network and Out-of-Network services the \$50/\$25 copayment is waived if admitted.*

***Out-of-Network benefit does not apply if non-emergent.*

Hospital Charges

In-Network **100 percent** coverage
Out-of-Network **70/80 percent** coverage, subject to precertification and hospital deductible of \$200 per hospital stay under most plans (Exception: the School Employees' Plan)

Home Health Care

In-Network **100 percent** coverage (no copayment)
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Hospice Care

In-Network **100 percent** coverage (no copayment)
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Inherited Metabolic Disease Medical Foods

In-Network **90 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Inpatient Physician Services

In-Network **100 percent** coverage (no copayment)
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Maternity/Obstetrical Care

In-Network **100 percent** coverage after a copayment for initial visit
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Non-Biologically-Based Mental or Nervous Conditions

• **Inpatient**

In-Network **Inpatient: 100 percent** up to 25 days per calendar year; balance at **90 percent** up to annual and lifetime maximum

Outpatient: 90 percent of reasonable and customary allowance up to annual and or lifetime maximum

Out-of-Network **Inpatient: 50 days** per calendar year at **50 percent** after deductible; up to annual and/or lifetime maximums

Outpatient: 70/80 percent of the reasonable and customary allowance up to the annual and lifetime mental health maximums

• **Inpatient Medical Visits**

In-Network **100 percent** coverage, subject to the annual/lifetime maximum

Out-of-Network **70/80 percent** of the reasonable and customary allowance, subject to the annual/lifetime maximum

Nutritional Counseling

In-Network **100 percent** coverage (3 visits per year)

Out-of-Network **No coverage**

Physical Therapy and Occupational Therapy

In-Network **100 percent** coverage

Out-of-Network **70/80 percent** of the reasonable and customary allowance

Pre-Admission Testing

In-Network **100 percent** coverage (no copayment)

Out-of-Network **70/80 percent** of the reasonable and customary allowance

Preventive Care

• **Gynecological Care and Examinations (Routine)**

In-Network **100 percent** coverage

Out-of-Network Coverage for one routine annual exam only. Care for treatment of a diagnosed condition is covered at **70/80 percent** of the reasonable and customary allowance.

Preventive Care *(continued)*

- **Mammography**

In-Network **100 percent** coverage (no copayment)

Out-of-Network Coverage for one routine mammography is eligible at the Out-of-Network level and is covered at **70/80 percent** of the reasonable and customary allowance

- **PAP Smears**

In-Network **100 percent** coverage

Out-of-Network **70/80 percent** of the reasonable and customary allowance for an annual routine pap smear

- **Routine Physicals and Immunizations**

In-Network **100 percent** coverage

Out-of-Network **No coverage**

- **Well-Child Care**

In-Network **100 percent** coverage

Out-of-Network **No coverage**

- **Well-Child Immunizations**

In-Network **100 percent** coverage

Out-of-Network **70/80 percent** of the reasonable and customary allowance, under 12 months of age only

- **Prostate Cancer Screening**

In-Network **100 percent** coverage

Out-of-Network **No coverage**

Private Duty Nursing (Outpatient)

In-Network **90 percent** coverage

Out-of-Network **70/80 percent** of the reasonable and customary allowance

Second Surgical Opinion Charges (Voluntary)

In-Network **100 percent** coverage

Out-of-Network **70/80 percent** of the reasonable and customary allowance

Skilled Nursing Facility Charges

Combined In-Network and Out-of-Network Maximum of 120 Days

In-Network **100 percent** coverage for up to 120 days per calendar year (no copayment)

Out-of-Network **70/80 percent** of the reasonable and customary allowance up to 60 days per calendar year

Specialist Services

In-Network **100 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Specialized Non-Standard Infant Formula

In-Network **90 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Speech Therapy

In-Network **100 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Surgical Services

In-Network **100 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

Transplant Benefits

In-Network **100 percent** coverage
Out-of-Network **70/80 percent** of the reasonable and customary allowance

APPENDIX III

GLOSSARY

Accidental Injury — Physical harm or damage done to a person as a result of a chance or unexpected occurrence.

Active Group Member (subscriber) — An employee who has met the requirements for participation and has completed a form constituting written notice of election to enroll for coverage in the SHBP for him or herself and, if applicable, any eligible dependents. Also includes eligible employees or dependents who continue SHBP coverage as a subscriber in the SHBP's COBRA program.

Activities of Daily Living — Day-to-day activities, such as dressing, feeding, toileting, transferring, ambulating, meal preparation, and laundry functions.

Allowable Expense — The allowance for charges for services rendered or supplies furnished by a health care provider that would qualify as a covered expense.

Ambulatory Surgical Center — An accredited ambulatory care facility licensed as such by the state in which it operates to provide same-day surgical services.

Appeal — A request made by a member, doctor, or facility that a carrier review a decision concerning a claim. Administrative appeals question plan benefit decisions such as whether a particular service is covered or paid appropriately. Medical appeals refer to the determination of need or appropriateness of treatment or whether treatment is considered experimental or educational in nature. Appeals to the Health Benefits Commission may only be filed by a member or the member's legal representative.

Benefit Period — The twelve-month period starting on January 1st and ending on December 31st. The first and/or last Benefit Period may be less than a calendar year. The first Benefit Period begins on your coverage date. The last Benefit Period ends when you are no longer covered.

Biologically-Based Mental Illness — Diagnosed conditions including schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive compulsive disorder, panic disorder, and pervasive developmental disorder or autism.

Calendar Year — A year starting January 1 and ending on December 31.

Case Manager — A person or entity designated by the plan to manage, assess, coordinate, direct, and authorize the appropriate level of health care treatment.

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

COBRA — Consolidated Omnibus Budget Reconciliation Act of 1985. This federal law requires private employers with more than 20 employees and all public employers to allow covered employees and their dependents to remain on group insurance plans for limited time periods at their own expense under certain conditions.

Coinsurance — The portion of an eligible charge which is the member's financial responsibility for out-of-network services.

Coordination of Benefits — The practice of correlating the payments a plan makes with payments provided by other insurance covering the same charges or expenses, so that (1) the plan with primary responsibility pays first, (2) reimbursement does not exceed 100 percent of the actual expense, and (3) the plan does not pay more than it would if no other insurance existed.

Copayment — The fee charged to a member or patient to be paid directly to the participating provider or network specialist at the time treatment is rendered for certain covered services.

Cosmetic Services — Services rendered to refine or reshape body structures or surfaces that are not functionally impaired. They are to improve appearance or self-esteem, or for other psychological, psychiatric or emotional reasons.

Covered Person (member) — An employee, retiree, or COBRA participant or a dependent of an employee, retiree, or COBRA participant who is enrolled.

Coverage — The plan design of payment for medical expenses under the program.

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

Dependent — A member's spouse or same-sex domestic partner (as defined by Chapter 246, P.L. 2003) and unmarried child(ren) under the age of 23 who lives with and is substantially dependent upon the member for support. Children include natural, adopted, foster, and stepchildren. If a covered child is not capable of self-support when he or she reaches age 23 due to mental illness, mental retardation, or a physical disability, coverage under the SHBP may be continued.

Deductible — The portion of the first eligible charges submitted for payment in each calendar year that the out-of-network portion of NJ DIRECT requires the member or covered dependent to pay.

Detoxification Facility — A health care facility licensed by the state it is in as a detoxification facility for the treatment of alcoholism and/or substance abuse.

Domestic Partner — Domestic partner SHBP coverage is only available to State employees/retirees and to Local/Educational employees/retirees whose employer has adopted a resolution to participate in health benefits coverage under Chapter 246, P.L. 2003, the Domestic Partnership Act. Under the Act, a domestic partner is defined for SHBP eligibility as a person of the same sex with whom the employee or retiree has entered into a domestic partnership by registering with the local registrar and receiving a Certificate of Domestic Partnership from the State of New Jersey (or a valid certification from another jurisdiction that recognizes same-sex domestic partners, civil unions, or similar same-sex relationships). The cost of domestic partner coverage may be subject to federal tax (see your employer or [Fact Sheet #71](#), *Benefits Under the Domestic Partnership Act*, for more information).

Durable Medical Equipment — Equipment, which is designed and able to withstand repeated use and is customarily used to serve a member with a medical condition.

Eligible Services and Supplies — These are the charges that may be used as the basis for a claim. They are the charges for certain services and supplies to the extent the charges meet the terms as outlined below:

- Medically needed at the appropriate level of care for the medical condition.
- Listed in covered services and supplies.
- Ordered by a doctor (as defined by NJ DIRECT) for treatment of illness or injury.
- Not specifically excluded (listed in the “Charges Not Covered by NJ DIRECT” section on page 35).
- Provided while you or your eligible family members were covered by NJ DIRECT.

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

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

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

Employer — The State, or a local public employer which participates in the State Health Benefits Program.

Facility Charges — Charges from an eligible medical institution such as a hospital, residential treatment center, detoxification center, ambulatory or separate surgical center, dialysis center, or a skilled nursing center.

Family or Medical Leave of Absence — A period of time of pre-determined length, approved by the employer, during which the employee does not work, but after which the employee is expected to return to active service. Any employee who has been granted an approved leave of absence in accordance with the Family and Medical Leave Act of 1993 shall be considered to be active for purposes of eligibility for covered services and supplies under your group's program.

Full Medicare Coverage — Enrollment in both Part A (Hospital Insurance) and Part B (Medical Insurance) of the federal Medicare Program. ***State law requires that anyone who is enrolled in the Retired Group and is eligible for Medicare must enroll in both Parts A and B of the Medicare Program in order to be covered in the State Health Benefits Program.***

Gestational Carrier — A woman who has become pregnant with an embryo or embryos that are not part of her genetic or biologic entity, and who intends to give the child to the biological parents after birth.

Government Hospital — A hospital which is operated by a government or any of its subdivisions or agencies. This includes any federal, military, state, county, or city hospital.

Home Health Care Agency — A provider which mainly provides skilled nursing care and therapeutic services for an ill or injured person in the home under a home health care program designed to eliminate hospital stays. To be eligible for reimbursement it must be licensed by the state in which it operates, or be certified to participate in Medicare as a home health care agency.

Hospice — A provider that renders a health care program which provides an integrated set of services designed to provide comfort, pain relief and supportive care for terminally ill or terminally injured people under a hospice care program.

Hospital — An approved institution that meets the tests of 1, 2, 3, 4, or 5, listed below:

1. It is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Hospitals and Medicare approved.
2. It (a) is legally operated, (b) is supervised by a staff of doctors, (c) has 24-hour-a-day nursing service by registered graduate nurses, and (d) mainly provides general inpatient medical care and treatment of sick and injured persons by the use of the medical, diagnostic, and major surgical facilities in it.
3. It is licensed as an ambulatory or separate surgical center. The center must mainly provide outpatient surgical care and treatment.
4. It is an institution for the treatment of alcoholism not meeting all the tests of (1) or (2) but which is:
 - A licensed hospital; or
 - A licensed detoxification facility; or
 - A residential treatment facility which is approved by a state under a program that meets standards of care equivalent to those of the Joint Commission on Accreditation of Hospitals. (Educational services provided while at an approved treatment facility is not eligible)
5. It is a birth center that is licensed, certified, or approved by a department of health or other regulatory authority in the state where it operates or meets all of the following tests:
 - It is equipped and operated mainly to provide an alternative method of childbirth.
 - It is under the direction of a doctor.
 - It allows only doctors to perform surgery.
 - It requires an exam by an obstetrician at least once before delivery.
 - It offers prenatal and postpartum care.
 - It has at least two birthing rooms.
 - It has the necessary equipment and trained people to handle foreseeable emergencies. The equipment must include a fetal monitor, incubator, and resuscitator.
 - It has the services of registered graduate nurses.
 - It does not allow patients to stay more than 24 hours.
 - It has written agreements with one or more hospitals in the area that meet the tests listed above in (1) or (2) and will immediately accept patients who develop complications or require post-delivery confinement.

- It provides for periodic review by an outside agency.
- It maintains proper medical records for each patient.

“**Hospital**” does not include a nursing home. Neither does it include an institution, or part of one, that:

- Is used mainly as a place for convalescence, rest, nursing care, or for the aged or drug addicts.
- Is used mainly as a center for the treatment and education of children with mental disorders or learning disabilities.
- Provides home-like or custodial care.

Illness — Any disorder of the body or mind.

Injury — Damage to the body.

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

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

Maintenance Care — Maintenance care is care that does not substantially improve the condition. When care is provided for a condition that has reached maximum improvement and further services will not appreciably improve the condition, care will be deemed to be maintenance care and no longer eligible for reimbursement. Maintenance care services, even those that are considered to be medically needed, are not eligible for coverage under NJ DIRECT.

Medical Need and Appropriate Level of Care — A service or supply that NJ DIRECT determines meets **each** of these requirements:

- It is ordered by a doctor for the diagnosis or the treatment of an illness or injury.
- The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use, and that its omission would adversely affect the person's medical condition.
- That it is the most appropriate level of service or supply considering the potential benefits and harm to the patient.

- It is known to be effective in improving health outcomes (for new interventions, effectiveness is determined by scientific evidence; then, if necessary, by professional standards; then, if necessary, by expert opinion).

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

Member — An employee, retiree, COBRA enrollee or dependent who is enrolled under NJ DIRECT.

Mental or Nervous Condition — A condition which manifests symptoms which are primarily mental or nervous, whether organic or non-organic, biological or non-biological, chemical or non-chemical in origin and regardless of cause, basis or inducement, for which the primary treatment is psychotherapy or psychotherapeutic methods or psychotropic medication. Mental or nervous conditions include, but are not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. Mental or nervous condition does not include substance abuse or alcoholism.

Morbid Obesity — A body mass index (BMI) greater than 40kg/m², or a BMI greater than 35kg/m² with associated life-threatening or disabling co-morbidities including, but not limited to, coronary heart disease, diabetes, hypertension, or obstructive sleep apnea.

Mouth Condition — A condition involving one or more teeth, the tissue or structure around them, or the alveolar process of the gums.

Off-Label Use — A drug not approved by the FDA for treatment of the condition in question or prescribed at a different dosage than the approved dosage.

Out-of-Network Benefits — Benefits provided by NJ DIRECT when members do not use network providers for their medical treatment or do not follow the managed care guidelines.

Participating Provider — A doctor or hospital which has a written agreement NJ DIRECT to provide care.

Precertification — A process by which the eligibility and medical appropriateness of services or supplies is determined before services are rendered.

Primary Health Plan — A plan which pays benefits for a member's covered charge first, ignoring what the member's secondary plan pays. A secondary health plan then pays the remaining unpaid expenses in accordance with the provisions of the member's secondary health plan.

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

Reasonable and Customary — NJ DIRECT covers only reasonable and customary allowances, which are determined by the prevailing Healthcare Charges system (PHCS) fee schedule. This schedule is based on actual charges by physicians in a specific geographic

area for specific service. If your physician charges more than the reasonable and customary allowance, you will be responsible for the full amount above the reasonable and customary allowance in addition to any deductible and coinsurance you are required to pay. This schedule is updated on a semi-annual basis.

Residential Treatment Facility — A health care facility licensed, by the State of New Jersey for treatment of alcoholism or substance abuse or meeting the same standards, if out-of-state.

Respite Care — Short-term or temporary care provided for the hospice patient in order to provide relief, or respite to the family caregiver.

Retired Group Member — An eligible retiree of a state-administered or local public pension fund who has met the requirements for participation and has completed a form constituting written notice of election to enroll for coverage in the Retired Group of the SHBP for him/herself and, if applicable, any eligible dependents. Also includes a surviving spouse of a deceased Retired Group member who has met the requirements for and has completed a form constituting written notice of election to enroll for coverage in the Retired Group of the SHBP for him/herself and, if applicable, any eligible dependents. Also includes a surviving dependent child of a deceased Retired Group member who had parent-child(ren) coverage, providing he or she has completed a form constituting written notice of election to enroll for coverage in the Retired Group of the SHBP.

Skilled Nursing Facility — A facility which is approved by either the Joint Commission on Accreditation of Health Care Organizations or the Secretary of Health and Human Services and provides skilled nursing care and services to eligible persons. The skilled nursing facility provides a specific type of treatment that falls midway between a hospital that provides care for acute illness and a nursing home that primarily provides custodial, maintenance or supportive care as well as assistance with daily living.

State Biweekly Employee — For purposes of SHBP coverage, state biweekly employee shall mean a full-time employee of the State, or an appointed or elected officer, paid by the State's centralized payroll system whose benefits are based on a biweekly cycle. Full-time normally requires 35 hours per week.

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

State Monthly Employee — For purposes of SHBP coverage, state monthly employee shall mean a full-time employee of the State, or an appointed or elected officer, whose benefits are based on a monthly cycle and whose payroll system is autonomous (not paid by the State's centralized payroll system). Full-time shall mean the usual full-time weekly schedule for the particular title, which normally requires 35 hours per week.

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

- Rutgers, the State University of New Jersey
- Palisades Interstate Park Commission
- New Jersey Institute of Technology
- University of Medicine & Dentistry of NJ
- Thomas A. Edison State College
- William Paterson University
- Ramapo State College
- Rowan University
- College of New Jersey
- Montclair State University
- New Jersey City University
- Kean University
- Stockton State College
- New Jersey State Library
- New Jersey State Legislature and Legislative Offices
- New Jersey Building Authority
- New Jersey Commerce and Economic Growth Commission
- Waterfront Commission of New York Harbor
- Agencies or special projects that are supported from, or whose employees are paid from, sources of revenue other than general funds, which other funds shall bear the cost of benefits under this program

Substance Abuse — The abuse of or addiction to drugs or controlled substances, not including alcohol.

Supportive Care — Care for patients that have reached the maximum therapeutic benefit in whom periodic trials of therapeutic withdrawals fail to sustain previous therapeutic gains. Supportive care services, even those that are considered to be medically appropriate are not eligible for coverage under NJ DIRECT.

Surgical Center — Also called a surgicenter. An ambulatory-care facility licensed by a state to provide same-day surgical services.

Surgical Procedure — This includes cutting, suturing, treatment of burns, correction of fracture, reduction of dislocation, manipulation of joint under general anesthesia, application of plaster casts, electrocauterization, tapping (paracentesis), administration of pneumothorax, endoscopy, or injection of sclerosing solution.

Surrogate — A woman who carries an embryo that was formed from her own egg inseminated by the sperm of a designated sperm donor.

Waiting Period — The period of time between enrollment in the State Health Benefits Program and the date when you become eligible for benefits.

APPENDIX IV

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

NJ DIRECT meets the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 requirements.

Certification of Coverage

HIPAA rules state that if a person was previously covered under another group health plan, that coverage period will be credited toward any pre-existing condition limitation period for the new plan. This includes any prior group plan coverage that was in effect 90 days prior to the individual's effective date under the new plan. A *Certification of Coverage* form, which verifies your SHBP group health plan enrollment and termination dates, is available through your payroll or human resources office, should you terminate your coverage.

HIPAA Privacy

The State Health Benefits Program makes every effort to safeguard the health information of its members and complies with the privacy provisions of HIPAA, which requires that health plans maintain the privacy of any personal information relating to its members' physical or mental health. See page 70 for the State Health Benefits Program's [*Notice of Privacy Practices*](#).

APPENDIX V

NOTICE OF PRIVACY PRACTICES TO ENROLLEES IN THE NEW JERSEY STATE 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.

EFFECTIVE DATE: APRIL 14, 2003

Protected Health Information

The State Health Benefits Program (SHBP) is 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 SHBP 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 SHBP through various sources, such as enrollment forms, employers, health care providers, federal and State agencies, or third-party vendors.

The SHBP is required by law to abide by the terms of this Notice. The SHBP reserves the right to change the terms of this Notice. If the SHBP makes material change to this Notice, a revised Notice will be sent.

SHBP Uses and Disclosures of PHI

The SHBP 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 SHBP 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 SHBP may disclose PHI to a doctor or a hospital to assist them in providing a member with treatment.
- The SHBP may use and disclose member PHI so that our Business Associates may pay claims from doctors, hospitals, and other providers.
- The SHBP 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 SHBP and/or our Business Associates may use and disclose PHI to investigate a complaint or process an appeal by a member.

- The SHBP 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 SHBP may use PHI to bill the member for the appropriate premiums and reconcile billings we receive from our Business Associates.
- The SHBP may use and disclose PHI for fraud and abuse detection.
- The SHBP 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 SHBP may use and disclose PHI in response to a court or administrative order as provided by law.
- The SHBP 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 SHBP 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 SHBP will provide access to PHI only to the member, the member's authorized representative, and those organizations who need the information to aid the SHBP 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 SHBP 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 SHBP maintains physical, technical and procedural safeguards that comply with federal law regarding PHI.

Member Rights

Members of the SHBP 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 SHBP maintains in a designated record set which consists of all documentation relating to member enrollment and the SHBP'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 SHBP 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 SHBP 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 SHBP; 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 SHBP 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 SHBP place restrictions on the use or disclosure of their PHI for treatment, payment, or health care operations purposes. The SHBP 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 SHBP 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 SHBP 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 SHBP using the information listed at the end of this Notice.

If members think the SHBP 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 SHBP 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 SHBP supports member rights to protect the privacy of PHI. It is your right to file a complaint with the SHBP or with the US Department of Health and Human Services.

Right to Receive a Paper Copy of the Notice: Members are entitled to receive a paper copy of this Notice. Please contact us using the information at the end of this Notice.

Contact Office:

Division of Pensions and Benefits — HIPAA Privacy Officer

Address:

**State of New Jersey
Department of the Treasury
Division of Pensions and Benefits
PO Box 295
Trenton, NJ 08625-0295**

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

APPENDIX VI

STATE HEALTH BENEFITS PROGRAM CONTACT INFORMATION

Addresses

NJ DIRECT — Horizon Blue Cross Blue Shield of New Jersey

Mailing Address:

**Horizon BCBSNJ
PO Box 820
Newark, NJ 07101-0820**

Internet Address: www.horizonblue.com/shbp

Division of Pensions and Benefits — State Health Benefits Program

Mailing Address:

**The State Health Benefits Program
Division of Pensions and Benefits
PO Box 299
Trenton, NJ 08625-0299**

Internet Address: www.state.nj.us/treasury/pensions/shbp.htm

E-mail Address: pensions.nj@treas.state.nj.us

Telephone Numbers

NJ DIRECT

Horizon Blue Cross Blue Shield of New Jersey 1-800-414-7427 (SHBP)

Division of Pensions and Benefits:

Automated Information System (609) 777-1931

Office of Client Services (609) 292-7524

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

State Employee Advisory Service (EAS) 24 hours a day 1-866-327-9133

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 Board.....1-800-838-0935

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..... 1-800-Medicare

New Jersey Medicare – Part A.....1-866-641-2007

New Jersey Medicare – Part B.....1-800-462-9306

STATE HEALTH BENEFITS PROGRAM PUBLICATIONS

Fact sheets, handbooks, and other publications are available for viewing or printing over the Internet at: www.state.nj.us/treasury/pensions

General Publications

[State Health Benefits Program Summary Program Description](#) booklet

[State Health Benefits Program Comparison Summary](#) - Plan comparison chart.

[Fact Sheet #11](#), *Enrolling in the State Health Benefits Program When You Retire.*

[Fact Sheet #23](#), *The State Health Benefits Program 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 New Jersey State Health Benefits Program Coverage Under COBRA.*

[Fact Sheet #31](#), *Benefits at Termination of Employment.*

[Fact Sheet #37](#), *SHBP Employee Dental Plans.*

[Fact Sheet #47](#), *SHBP Retired Coverage Under Chapter 330 (PFRS, LEO).*

[Fact Sheet #51](#), *Continuing SHBP Coverage for Over Age Children with Disabilities.*

[Fact Sheet #60](#), *Voluntary Furlough Program.*

[Fact Sheet #66](#), *SHBP 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](#), *SHBP Coverage of Children to Age 30 Under Chapter 375.*

[Fact Sheet #75](#), *Civil Unions.*

SHBP Member Handbooks

[NJ DIRECT Member Handbook](#)

[Aetna HMO Member Handbook](#)

[CIGNA HealthCare HMO Member Handbook](#)

[SHBP Employee Prescription Drug Plan Member Handbook](#)

[SHBP Employee Dental Plans Member Handbook](#)

[SHBP Retiree Dental Expense Plan Member Handbook](#)

