



State of New Jersey  
DEPARTMENT OF THE TREASURY  
DIVISION OF PENSIONS AND BENEFITS  
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June 2007

**TO:** State Departmental Certifying Officers  
State Human Resources Directors  
State Biweekly Human Resources Representatives  
State Monthly Certifying Officers  
State Monthly Human Resources Representatives

**FROM:** Florence J. Sheppard   
Deputy Director, Benefit Operations

**SUBJECT: State Health Benefits Program Plan Changes**

**NEW COPAYMENT AND CONTRIBUTION AMOUNTS EFFECTIVE JULY 2007**

The State and the CWA, AFSCME, and IPFTE have agreed to new medical and prescription drug plan copayment amounts for their members. In addition, an agreement was reached to require a health care contribution for any employees covered under the labor groups mentioned above and who are enrolled in the SHBP as an employee for health and/or prescription drug coverage. Employees with no majority representation for collective negotiation purposes are also affected by these changes.

The changes are effective July 7, 2007 for State biweekly employees and July 1, 2007 for State monthly employees. The contribution change is effective September 1, 2007 for employees paid on a 10-month basis. Additional labor bargaining groups may be added to the employees affected by these changes as pending labor contracts are settled.

The copayment and contribution changes are outlined below.

- For **NJ PLUS** and **all HMOs** (Aetna, AmeriHealth, CIGNA, Health Net and Oxford), the copayment for primary doctor visits and visits to a specialist will be \$15. The copayment for a visit to an emergency room will be \$50. The emergency room copayment is waived if the member is admitted to the hospital.
- The structure of the prescription drug benefit has been modified to include a third tier of copayments. The copayment for each 30 day supply when purchased at a retail pharmacy will remain \$3 for generic drugs and \$10 for brand name prescription drugs without generic equivalents. The new third tier will include a \$25 copayment for brand name drugs where a generic equivalent is available for a 30 day supply purchased at a retail pharmacy. The mail order prescription drug copayments, for up to a 90-day supply, will remain \$5 for generic drugs and \$15 for brand name drugs without generic equivalents. The third tier mail order

copayment will be \$40 for brand name drugs where a generic equivalent is available.

- Employees enrolled in the SHBP for health and/or prescription drug coverage will be required to contribute 1.5% of their annual base salary. The contribution amount will change any time there is a change in an employee's base annual salary. The contribution is the same regardless of the medical plan or level of coverage that is selected.

Employees will be permitted to waive their SHBP medical and prescription coverage to avoid the 1.5% contribution from salary — provided they have other health care coverage. Employees may also add dependents who have lost health coverage to their current coverage through August 31, 2007. An *SHBP State Waiver* form (enclosed) and *SHBP Application* are required to be submitted through the employer to the SHBP.

Please note, however; that employees will not be permitted to change medical plans (i.e. from NJ PLUS to the Traditional Plan, etc.). That opportunity will be afforded during the annual open enrollment in October, 2007 with changes effective for January 2008.

#### **NEW CONTRIBUTION AMOUNTS FOR RETIREES**

The copayment changes mentioned above for visits to a doctor, a specialist or emergency room, and for prescription drugs will not apply to retirees at this time.

Employees affected by these changes who attain 25 years of pension membership credit on or after July 1, 2007 — or who retire on a disability on or after August 1, 2007 — will be required to contribute 1.5% of their pension allowance for SHBP coverage in retirement regardless of the medical plan or level of coverage selected.

Employees who attained 25 years of pension membership credit on or before June 30, 2007 will premium share for SHBP coverage in retirement based on the labor contract in effect at the time they attained the 25 years of pension membership credit.

#### **NEW SHBP PLAN OFFERINGS**

The State Health Benefits Commission has issued a *Request for Proposal* (RFP) for a new Preferred Provider Organization (PPO) and for HMO plans. The prospective effective date for the new health plan contracts is April 1, 2008. As a result, SHBP members should be made aware that there will be a special SHBP Open Enrollment to be held early in 2008.

Additional information about the plan redesign will be made available later in the RFP process. The RFP is available for viewing at the SHBP Web site at: [www.state.nj.us/treasury/pensions/shbp.htm](http://www.state.nj.us/treasury/pensions/shbp.htm)

Enclosure

*SHBP State Waiver/Reinstatement* form

STATE OF NEW JERSEY  
DEPARTMENT OF THE TREASURY  
DIVISION OF PENSIONS AND BENEFITS  
PO BOX 299  
TRENTON, NJ 08625-0299

**STATE HEALTH BENEFITS PROGRAM COVERAGE  
STATE EMPLOYEE WAIVER/REINSTATEMENT**

**Part 1:** To be completed by the employee. Please print.

1. Name \_\_\_\_\_ SS# \_\_\_\_\_

Check one box below.

**Waiver of Coverage**

I agree to voluntarily waive State Health Benefits Program (SHBP) coverage to which I am entitled because I am covered under other health coverage. I understand that while coverage is waived, I will not be required to make payroll contributions required for medical and/or prescription drug coverage.

I understand that I may resume State Health Benefits Program coverage if I lose coverage under the other health coverage, provided that I notify the SHBP within 60 days of the loss of the other coverage and provide proof of loss of that coverage.

**Reinstatement of Coverage**

I previously waived State Health Benefits Program coverage because I had other health coverage.

As of \_\_\_\_\_, I am no longer covered by the other health plan, request reinstatement of the State  
(date)  
Health Benefits Program coverage, and have provided proof of loss of the other coverage.

**Employee's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Part 2:** To be completed by the employer. Check one box below.

We understand that this employee is requesting to voluntarily waive State Health Benefits Program coverage.

We request reinstatement of this employee's State Health Benefits Program coverage.

**A completed State Health Benefits Program Application must be attached to either a waiver or a reinstatement.**  
The reinstatement application must be filed within 60 days of the loss of other health coverage. If this timetable is followed, the coverage will be retroactive to the date of loss. If the 60 day time limit has passed, the employee must wait until the next open enrollment period to reenroll.

Employer Name \_\_\_\_\_ SHBP Location # \_\_\_\_\_

Signature of Certifying Officer \_\_\_\_\_ Date \_\_\_\_\_