



# City of Newark

## GUIDE TO SELECTION OF HEALTH BENEFITS FOR 2012

BOOKLET EFFECTIVE JANUARY 1 TO DECEMBER 31, 2012

The purpose of this booklet is to provide you with general information regarding your health benefit options offered through the City of Newark. Eligible individuals are encouraged to review the content of this booklet prior to enrolling in their benefit options.

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### **In Review:**

Throughout 2011, the City has been actively engaged in exploring opportunities to enhance the medical benefits it offers to active employees, retirees and their eligible dependents, and to simultaneously explore every option to control rapidly spiraling health costs. Additionally, the City has also been committed to simplifying and expediting the claims processing experience to save you time and money.

In 2011, the City continued its efforts to provide you with superior coverage while meeting its ongoing obligation to manage the challenges associated with rapidly escalating health care coverage costs. To accomplish these goals, on January 1, 2010, the City introduced the Horizon Direct Access Plan which replaced the Horizon HMO and Aetna HMO Plans. The Direct Access Plan offers 100% coverage after the payment of a small co-pay for all covered in-network services. The Direct Access does not require you to first see a primary care physician; second you will have access to certain out of network benefits through the Blue-Card PPO network and third, you will have access to a national network of providers rather than being limited to providers located in New Jersey.

At the beginning of 2010, the City also began offering you the opportunity to join Horizon's Dental Choice Plan E which is a Dental Maintenance Organization Plan that offers many routine dental services covered at 100% with no Plan maximum. For much more detailed information about the Direct Access Plan and Horizon's Dental Choice Plan E, as well as the currently offered consolidated Traditional Plan please refer to pages 3-5 and 11 in this Booklet. Please also refer to page 13 in this Booklet to learn about the employee contribution schedule that will be in effect in 2012.

### **NEW FOR 2012:**

As per Chapter 78, which took effect on June 28, 2011, the City will offer a third medical plan option. The Horizon Advantage Exclusive Provider Organization (EPO) plan delivers in-network only benefits through the Horizon Managed Care Network (the same network as the current Direct Access Plan). The plan also offers the expanded BlueCard® PPO program for members outside New Jersey. EPO members have in-network access only; out-of-network coverage is only provided in medical emergencies. This plan is a lower cost alternative and is strictly voluntary for 2012.

Chapter 78 also requires that the City establish a Flexible Spending Account (FSA). An FSA allows employees to use payroll withholdings of pretax dollars to pay for an out-of-pocket medical, dental, or vision expenses. The maximum amount you can set aside for the year is \$2,500. You must use all your funds in the calendar year of 2012 or you will lose access to those funds. More information on FSA's will be provided at the educational sessions. Please refer to page 2 of the booklet for dates, times and location.

### **OPEN ENROLLMENT/FAIR**

Open Enrollment is a time for you to make changes to your elections, enroll for the first time, and/or add/drop dependent coverage. Whatever you choose to do at this time will be effective January 1, 2012 through December 31, 2012. If you do not comply with the open enrollment guidelines with regard to providing necessary documents and/or the required forms within the allowed window of time, dependent coverage may be at risk and/or you may be denied a desired change with the next opportunity for changes being during next year's Open Enrollment. One exception which permits mid-year changes is qualifying events (i.e. marriage, divorce, birth, adoption, death of spouse, loss of spousal coverage).

The Fair which occurs during Open Enrollment provides you with the ability to meet representatives from each of the carriers that administer your various benefit programs and ask questions.

**Open Enrollment will be held this year from November 28, 2011 to December 16, 2011. The Open Enrollment Benefits Fair/Meeting Schedule is on Page 2.**

**Attention: If any inconsistencies exist between the information contained in this booklet and the provider contracts, the contracts prevail. Members should refer to their benefit booklets or contact the carrier on specific entitlement information.**

<b>Open Enrollment will be held this year from November 28, 2011 to December 16, 2011. The Open Enrollment Benefits Fair/Meeting Schedule is immediately below:</b>		
<b>Location</b>	<b>Address</b>	<b>Date/Time</b>
<b>POLICE COMMUNICATION BLDG (Police and Fire)</b>	311 WASHINGTON STREET	<b>Monday, November 28th</b> - 9:00 a.m. to 12:00 p.m. / <b>Friday, December 9th</b> - 9:00 a.m. to 12:00 p.m.
<b>LIBRARY</b>	5 WASHINGTON STREET	<b>Friday, December 2nd</b> – 9:00 a.m. to 12:00 p.m.
<b>CHILD &amp; FAMILY WELL BEING</b>	110 WILLIAM STREET	<b>Thursday, December 8th</b> – 9:00 a.m. to 12:00 pm
<b>SANITATION</b>	62 FRELINGHYSEN AVENUE	<b>Thursday, December 1st</b> - 6:00 a.m. to 8:00 a.m. and <b>Tuesday, December 6th</b> – 12:00 p.m. to 2:00 pm.
<b>WATER</b>	239 CENTRAL AVENUE	<b>Friday, December 2nd</b> - 2:00 p.m.- 4:00 p.m.
<b>FINANCE</b>	828 BROAD STREET - 4th Floor	<b>Thursday, December 1st</b> - 10:00 a.m. to 2:00 pm
<b>CITY HALL</b>	920 BROAD STREET - COUNCIL CHAMBERS (29th and 5th) / FIRST FLOOR ROTUNDA (29th only)	<b>Tuesday, November 29th - 9:00 a.m. - 2:00 p.m.</b> first floor Rotunda & Council Chambers / <b>Monday, December 5th - 9:00 a.m. to 2:00 p.m.</b> Council Chambers

**WHAT YOU NEED TO DO BY DECEMBER 16, 2011:**

As is the case during every Open Enrollment Period you need to make some very important decisions regarding the health coverage you will need to have during the upcoming year. If you are currently in the Traditional Plan or Direct Access Plan and you want to remain in the respective Plan in 2012, you do not need to do anything as you will be automatically enrolled. However, if you are currently in either the Traditional Plan or the Direct Access Plan and want to enroll in another plan you will need to complete an enrollment form which can be obtained by going to the Employee Benefits Unit, Room 211. If you are enrolled in the Group Health Administrator’s Plan, the Horizon Dental Option Plan or the Horizon Dental Choice Plan, and you want to remain in your plan for 2012, you do not need to do anything. If you want to enroll in any of the Dental plans that you are not currently in, you will need to complete an enrollment form.

Please remember that you will need to submit enrollment forms to the Employee Benefits Unit – City Hall Room 211 by December 16, 2011 if you plan to add or drop any dependents from your current coverage or if you plan to transition from the plan you are currently enrolled in. We encourage you to submit your changes as soon as possible but no later than December 16, 2011 to ensure that all of your coverage information is updated and accurate prior to January 1, 2012.

**The required enrollment forms must be submitted to the City’s Employee Benefits Unit no later than 12/16/11. The City will not be responsible for any claims that are incurred during your period of non-coverage.**

Should you have any questions, please contact the **City’s Employee Benefits Unit** at 973-733-3898 or the **Brown & Brown Employee Call Center** at 1-877-752-7587.

**MEDICAL PLAN OPTIONS**

For the January 1, 2012 to December 31, 2012 plan year, you will have access to three Medical Plan Options as follows:

- Horizon Direct Access
- Horizon Traditional
- Horizon EPO

The Direct Access plan provides 100% coverage after payment of a small copay for all covered in-network services. Out-of-network coverage is available under the Direct Access through the national Blue-Card PPO network. There is no Primary Care Physician selection requirement.

The Traditional plan, with both hospital and major medical services consolidated under Horizon BCBSNJ (as of June 1, 2009), pays 80% of all covered services after satisfaction of the applicable calendar year deductible. Network and Non-Network providers are accessible under the Traditional plan and there is no Primary Care Physician selection requirement.

The Horizon Advantage Exclusive Provider Organization (EPO) plan delivers in-network only benefits through the Horizon Managed Care Network. The plan also offers the expanded BlueCard® PPO program for members outside New Jersey. EPO members have in-network access only; out-of-network coverage is only provided in medical emergencies. There is no Primary Care Physician selection requirement.

There is nothing for you to do UNLESS you are making a change. "Changes" consist of:

- Adding or dropping dependents
- Moving from your current plan to a different plan.

If you are making any of these changes, you MUST submit an enrollment form. The deadline for receipt by the Employee Benefits Unit - City Hall - Room 211 is December 16, 2011. By submitting your changes early, you are ensuring that all of your coverage information is updated / accurate.

**Horizon's Hospital Network is subject to change from time to time. Horizon's eligible benefit level is significantly reduced when using an out of network hospital. We strongly urge members to access Horizon's website to obtain the most up-to-date network information. Members may also contact Horizon directly by calling 1-800-355-BLUE or by going to the website at [www.horizonblue.com](http://www.horizonblue.com).**

### **Traditional Plan**

The Traditional plan is administered by Horizon Blue Cross Blue Shield of New Jersey. The plan provides indemnity style coverage.

#### *Plan Highlights*

The plan provides you with access to more than 31,000 participating physicians in New Jersey and over 15,000 in New York and Pennsylvania. By selecting a participating provider, you will receive the highest level of benefits and you will not have to file any claim forms. Eligible services include:

- Surgical Services
- Anesthesia Services
- Maternity Services
- Dental Surgery Services in a Hospital
- Emergency Medical Services

Subscribers should be mindful of the deadline for claims submission under the Traditional plan which is 18 months from the date of service.

### **Horizon Direct Access**

The Direct Access plan is a Managed Care plan which is similar to an HMO. It carries with it little or no out-of-pocket expenses for care received from Network providers. The major difference between the HMO and the Direct Access is the Out-of-Network coverage through the Direct Access plan. In-Network, the most an employee will pay is the copay, as applicable, with the balance of covered expenses paid at 100%. THIS PLAN IS SUPPORTED BY A NATIONAL NETWORK. BEST OF ALL, Primary Care Physician Referrals are NOT needed.

#### *Plan Highlights*

Preventive health care at low cost includes:

- Annual Physicals
- Well baby care
- Immunizations
- Gynecological exams and maternity care
- Annual Vision Exams
- Your Primary Physician and Participating Specialists will handle all paperwork.

**Horizon EPO**

The Exclusive Provider Organization (EPO) plan is very similar to the Direct Access plan with the same exact network (including Bluecard national and international access) and no primary care physician or referral requirements. However, there are **no out of network benefits**.

As an EPO member, you will only be responsible for your copay when applicable. All other eligible services are covered at 100% (except durable medical equipment which is covered at 50%). You just need to remain in-network for all services. In the event of a true emergency, services performed at the ER will be considered in-network regardless of the providers' network status.

The EPO plan is being offered to City employees as a lower cost option in response to the recent passing of Chapter 78 legislation.

**Horizon's Hospital Network is subject to change from time to time. Horizon's eligible benefit level is significantly reduced when using an out of network hospital. We strongly urge members to access Horizon's website to obtain the most up-to-date network information. Members may also contact Horizon directly by calling 1-800-355-BLUE or by going to the website at www.horizonblue.com.**

**Horizon BCBSNJ Comprehensive Disease Management Program.....**

...provides helpful information and guidance on managing chronic conditions. The program helps members manage their condition by providing education, counseling, and physician support. Members will receive educational materials and access to health care professionals via a 24 hour hot line. The program currently provides assistance with:

- Chronic Kidney Disease / Hepatitis C / Multiple Sclerosis / Diabetes / Heart Failure
- Coronary Artery Disease / Obstructive Pulmonary Disease / Asthma
- Weight Management

**BELOW YOU WILL FIND THE A SIDE BY SIDE COMPARISON OF THE THREE MEDICAL PLAN OPTIONS.**

BENEFITS	TRADITIONAL	DIRECT ACCESS		EPO
		IN-NETWORK	OUT OF NETWORK	IN-NETWORK ONLY
	Deductible	Deductible	Deductible	Deductible
HOSP/FACILITY	NONE	NONE	\$5000/PERSON \$10,000/FAMILY	NONE
PACE MEDICAL SURGICAL	NONE	NONE	\$5000/PERSON \$10,000/FAMILY	NONE
MAJOR MEDICAL	\$250/PERSON	NONE	\$5000/PERSON \$10,000/FAMILY	NONE
AMBULANCE	Covered at 80% of UCR after deductible	Covered in full.	Covered at 60% after deductible.	None – covered 100%
OTHER SERVICES, OUTPATIENT PHYSICAL THERAPY	Covered at 80% of UCR after deductible, subject to medical necessity.	Covered in full with \$15 copayment. Specialist office visit \$25. Limit of 30 visits per benefit period (In & Out Combined).	Covered at 60% after deductible. Limit of 30 visits per benefit period (In & Out Combined); \$1K/\$2K max/therapy.	100% after \$20 copay Limit of 30 visits per benefit period
EYE EXAMS	Not covered except for 1 routine exam every 5 years age 35 and over for glaucoma	Covered in full with \$15/\$25 copayment. One per year. Additional benefit: \$50 reimbursement for eyeglasses or contact lenses for each family member every 24 months.	Covered at 60% after deductible.	100% after \$20 copay Additional benefit: \$50 reimbursement for eyeglasses or contact lenses for each family member every 24 months.
BLOOD	Covered at 80% of UCR after deductible	Covered in full.	Covered at 60% after deductible.	100%
DENTAL SURGERY	Covered 100% of UCR for oral surgery on sound natural teeth as a result of accidents, cancerous lesions or restructuring of jaw and bony teeth impaction, excluding the extraction of teeth.	Covered in full for the removal of bony impacted teeth, or for injury to the jaw.	Covered 60% after deductible for the removal of bony impacted teeth, or for injury to the jaw.	Covered in full for the removal of bony impacted teeth, or for injury to the jaw.

BENEFITS	TRADITIONAL	DIRECT ACCESS		EPO
		IN-NETWORK	OUT OF NETWORK	IN-NETWORK ONLY
<b>MENTAL HEALTHCARE: OUTPATIENT</b>	Covered at 80% of UCR after deductible	Covered in full with \$15 copayment. Specialist office visit \$25.	Covered at 60% after deductible.	100% after \$20 copay
<b>INPATIENT (same as hospital)</b>	Covered at 100% of UCR after deductible up to 120 days then paid 80% after deductible up to 245 days	Covered in full.	Covered at 60% after deductible.	100%
<b>PROSTHETIC DEVICES</b>	Covered at 80% of UCR after deductible	Covered in full	Covered at 60% after deductible	100%
<b>INPATIENT HOSPITAL NUMBER OF DAYS</b>	Covered 100% up to 120 days; then paid 80% after deductible up to 245 days	Covered in full.	Covered at 60% after deductible.	Unlimited
<b>ROOM AND BOARD</b>	Covered 100% up to 120 days; then paid 80% after deductible up to 245 days	Covered in full.	Covered at 60% after deductible.	100%
<b>PHYSICIAN SERVICES SURGERY</b>	Covered up to 100% of UCR after deductible	Covered in full.	Covered at 60% after deductible.	100%
<b>CONSULTATION</b>	Covered up to 100% of UCR after deductible	Covered in full.	Covered at 60% after deductible.	100% after \$20 copay (only if done as part of an office visit)
<b>DOCTOR'S OFFICE VISIT</b>	When visit is related to treatment of illness, accident for injury, covered at 80% of UCR after deductible	Covered in full with \$15 copayment. Specialist office visit \$25.	Covered at 60% after deductible.	100% after \$20 copay
<b>PHYSICAL EXAMS</b>	Covered up to 100% of UCR after deductible	Covered in full with \$15 copayment. Specialist office visit \$25.	Covered at 60% no deductible.	100%
<b>PEDIATRIC EXAMS</b>	Covered up to 80% of UCR after deductible	Covered in full with \$15 copayment. Specialist office visit \$25.	Covered at 60% no deductible.	100% if preventative. Otherwise, 100% after \$20 copay
<b>X-RAYS</b>	Covered up to 80% of UCR after deductible	Covered in full.	Covered at 60% after deductible.	100%
<b>MATERNITY CARE OBSTERICAL CHARGE INCLUDING NORMAL DELIVERY</b>	Covered up to 100% of UCR after deductible	Covered in full with \$15/\$25 copay first visit only.	Covered at 60% after deductible.	100% after \$20 copay Copay first visit only
<b>HOSPITAL</b>	Covered 100% up to 120 days; then paid 80% after deductible up to 245 days	Covered in full.	Covered at 60% after deductible.	100%
<b>CESAREAN DELIVERY</b>	Covered up to 100% of UCR after deductible.	Covered in full.	Covered at 60% after deductible.	100%
<b>WELL BABY CARE</b>	Covered up to 80% of UCR after deductible	Covered in full with \$15 copayment. Specialist office visit \$25.	Covered at 60% no deductible.	100%
<b>EMERGENCY ROOM SERVICES. TREATMENT OF ILLNESS IN AREA TREATMENT OF INJURY</b>	Covered up to 100% of UCR after deductible. Covered up to 100% of UCR after deductible.	Covered in full.	Covered in full.	\$100 copay
<b>OUT OF AREA TREATMENT OF INJURY</b>	Covered up to 100% of UCR after deductible	Covered in full for reasonable charges. Emergencies covered worldwide.	Covered in full for reasonable charges. Emergencies covered worldwide.	100% if true emergency only
<b>CHIROPRACTIC SERVICES</b>	Covered at 80% of UCR after deductible; subject to medical necessity	Covered in full with \$15 copayment. Specialist office visit \$25. Limit of 25 visits per benefit period (In & Out Combined)	Covered at 60% no deductible. Limit of 25 visits per benefit period (In & Out Combined)	100% after \$20 copay Limit of 25 visits per member, per year.
<b>SUPPLEMENTAL BENEFITS, PRESCRIPTION DRUGS</b>	Available through City Rx Plan, if eligible. Otherwise Rx costs reimbursable under Major Medical.	Available through City Rx Plan, if eligible	Available through City Rx Plan, if eligible	Available through City Rx Plan, if eligible
<b>DEPENDENT AGE:</b>	26	26	26	26

## **Prescription Drug Coverage**

The City of Newark prescription drug benefits depend upon the union contractual agreements that apply to you. A brief description of each plan is below. Eligible dependents may be covered up to age 26. If you are unsure which level of benefits you are entitled to please contact the Employee Benefits Unit.

### **LEVEL ONE**

#### **Retail Prescription Drugs:**

\$1.50 for each Generic Drug or Supply  
\$1.50 for each Brand Name Drug or Supply

#### **Mail Order Prescription Drugs:**

\$0 for each Generic Drug or Supply  
\$0 for each Brand Name Drug or Supply

### **LEVEL TWO**

#### **Retail Prescription Drugs:**

\$1.50 for each Generic Drug or Supply  
\$5 for each Brand Name Drug or Supply

#### **Mail Order Prescription Drugs:**

\$0 for each Generic Drug or Supply  
\$0 for each Brand Name Drug or Supply

### **LEVEL THREE**

#### **Retail Prescription Drugs**

\$5 for each Generic Drug or Supply  
\$10 for each Brand Name Drug or Supply

#### **Mail Order Prescription Drugs:**

\$0 for each Generic Drug or Supply  
\$0 for each Brand Name Drug or Supply

On both plans, for medically necessary medications, one copayment will be applied for each 100 unit dose quantity. For orders which exceed 100 units copayments will be based on the day supply as follows:

1 to 34 day supply - 1 copayment  
35 to 60 day supply - 2 copayments  
60 to 90 day supply - 3 copayments

### **LEVEL FOUR**

#### **Retail/Mail Order Prescription Drugs**

20% of cost (coinsurance) for each Generic/Brand Drug or Supply

**For those of you who take any particular medication for more than 60 days, consider using Caremark's mail service program and pay less or no copay for each 90 day supply. Continue to next page to learn more about the benefits and advantages of utilizing Caremark's Mail Order program.**

## **Caremark Mail Service**

### **Spend less on your prescriptions!**

Take advantage of your Caremark mail service prescription benefit and you may save time and money on the medicines you take each month. Pay one low mail service copay for the extended supply of medicine (e.g. 90 days). Enjoy convenient delivery to the location of your choice, including standard shipping at no additional cost. Save time with online refills or refill-by-phone services – any time, any day.

### **Call for FastStart service today!**

Getting your prescription from the mail service pharmacy is simple with FastStart. **Easy as 1-2-3...**

1. Call FastStart toll-free at 1-866-776-5677
2. Let the FastStart representative know you wish to fill your prescription through mail service.
3. Provide the information on your prescription or medical ID card, the name(s) of the long term medication(s) you take, your doctor's name and phone number and your mailing address.

Once your doctor authorizes the prescription, you can expect to receive your medicine within 10 to 14 days from the date your order is received. FastStart is quick and convenient, saving you a trip to the doctor's office for a new prescription. This service is available for first time orders only. So act now and call today!

## **DENTAL PLAN OPTIONS**

City of Newark employees have three dental plans to choose from. Coverage is administered by Horizon Blue Cross Blue Shield of New Jersey Dental Programs, a powerful regional dental organization poised to meet the challenges of the ever-changing dental care market and Group Dental Health Associates.

### **Horizon Dental Choice Plan E**

Horizon Dental Choice Plan E is a Dental Maintenance Organization type of program. There are no deductibles to satisfy and there is NO annual maximum. When you utilize the services of an in-network dentist, most routine eligible services are covered at 100% while the more extensive services are paid at 100% after payment of the specified copay. Orthodontic benefits are included. A primary care dentist will facilitate all of your dental care and service needs. He/she will also provide you with the needed referral when the services of a specialist are required. This plan has no out-of-network benefits. Please note that if you have dental work in progress under the Group Dental Health Administrators Plan, you must wait until the work is completed and until the next open enrollment period to enroll in the Horizon Dental Choice Plan E.

### **Horizon Dental Option Plan**

Horizon Dental provides both in and out-of-network benefits. Benefits are reimbursed at 100%, 80% or 50% depending upon the type of services you receive. Network providers are required to accept Horizon's fee allowance. Since the fee allowance is typically significantly less than the prevailing or billed charge, you will save money by using an in-network dentist. Out-of-network dentists are reimbursed at 80% of the Usual, Customary, and Reasonable (UCR) allowance. Members are responsible for the coinsurance and the difference between billed charges and the UCR allowance.

### **Group Dental Health Administrators**

Please note Group Dental will offer you a very high level of benefits when you use a network provider. There is no out of network coverage. Group Dental Health Associates provides coverage when using their in-network providers. Offices are currently located in Newark, Roselle Park, East Brunswick, Toms River and Union. This plan does not include an annual maximum limit. Group Dental provides 100% coverage for many services and up to 80% for other eligible procedures. Eligible dependents may be covered up to age 26. Please review the dental plan comparison chart to obtain additional information.

**Please note that dependent limiting age varies for each union. If you are unsure as to which level of benefits you are entitled to please contact the Employee Benefits Unit.**

PLEASE SEE BELOW FOR A SIDE-BY-SIDE COMPARISON OF THE FEATURES FOR EACH PLAN

<b><u>Benefits</u></b>	<b><u>Horizon Dental Choice E</u></b>	<b><u>Horizon Dental Option</u></b>	<b><u>Group Dental Health Administrators, Inc.</u></b>
<b>Preventive &amp; Diagnostic</b>	100% Coverage	100% MAC	100% Coverage
<b>Treatment &amp; Therapy</b>	100% Coverage	80% MAC	100% Coverage
<b>Periodontia</b>	100% Coverage/Osseous surgery \$200	80% MAC	80% Coverage – 20% Co-payment of UCR (Usual Customary Rate) not to exceed \$500
<b>Oral Surgery</b>	100% Coverage	80% MAC	100% Coverage (w/local anesthesia and post operative care)
<b>Inlays &amp; Crowns</b>	\$30 - \$150 Per unit	80% MAC	\$75 for each crown/\$75 each tooth on a bridge
<b>Root Canal</b>	100%	80% MAC	100%
<b>Filling &amp; Restoration</b>	100%	80% MAC	100%
<b>Prosthodontia</b>	\$160 - \$170 Per unit / Denture Repairs \$20	50% MAC	\$75 Per Unit
<b>Orthodontia</b>	\$650 – Limited to one complete orthodontic treatment per lifetime for eligible population.	100% MAC (up to a lifetime maximum of \$1500) for eligible population.	\$650 – Maximum Patient Co-payment for up to 24 months of treatment for eligible population.
<b>Annual Maximum</b>	No Annual Maximum	\$1,000 or \$1,500	No Annual Maximum
<b>Dependent Age Limit</b>	19/23 if full-time student/dependent/(Some Unions age 23-check w/your Benefits Office in City Hall – 211)	19/23 if full-time student/dependent/(Some Unions age 23-check w/your Benefits Office in City Hall – 211)	Up to age 26
<b>Benefit Year</b>	Jan 1 – Dec 31	June 1 – May 31	Not Applicable
<b>Number of Providers</b>	194 Locations throughout New Jersey	14000 (NY, NJ, PA)	5 Office Locations - Newark, Roselle Park, East Brunswick, Toms River and Union.
<b>Miscellaneous</b>	Complete benefit summaries available in HR.	Complete benefit summaries available in HR. MAC – Maximum Allowable Charge. Based on in-network utilization	Complete benefit summaries available in HR.

**Important Notice: This is a sample of commonly utilized services and is not a comprehensive listing of your benefit plan. For complete benefit information, please refer to your benefit booklet or call your Customer service number for each plan.**

## **Voluntary Plans**

Should you have any questions regarding the voluntary (employee-paid) options available through the City of Newark feel free to contact the Brown & Brown Employee Benefits Service Center or the City's Employee Benefits Unit.

### **Employee Benefits Contacts**

#### **Division of Personnel -Employee Benefits Unit – City Hall Room 211**

The Employee Benefits Unit may be reached between the hours of Monday through Friday from 8:30 a.m. to 4:30 p.m. All employer funded enrollment requests (new enrollment, dependent addition/deletion, etc.) and inquiries should be directed to the Employee Benefits Unit. The benefits unit is also available to respond to Police and Fire Pension System related inquiries.

The contact numbers are 973-733-3898, 3693, 3987 and 8041.

#### **Brown & Brown Employee Benefits Service Center**

The Brown & Brown Employee Benefits Service Center is a resource for all City Employees/Retirees to reach out and get information regarding their benefits and general questions. The Service Center will be available Monday through Friday from 8:30AM to 6:00PM.

**Call 877-75-ASK US (27587) Extension 2135 or email [askus@bbmetro.com](mailto:askus@bbmetro.com)**

**It is important to note that if you have a question or concern with your benefits, need additional ID cards or have claim inquiries we do advise you to contact the respective carrier first.**

### **EMPLOYEE ASSISTANCE PROGRAM**

The City of Newark offers a comprehensive Employee Assistance Program (EAP) through Magellan Behavioral Health. This program provides easy to access services to assist employees and their dependents with life's challenges. Enrollment for full-time (non-seasonal) employees is automatic.

All calls and counseling sessions are confidential except as required by law (ex: In cases where a person's emotional condition is a threat to him/herself or others or when there is suspected abuse of a minor child, etc.)

In addition to the services reflected above, the EAP offers legal consultation services and useful online tools. Magellan can be reached 24 hours a day at (800) 424-1865 or via the internet at [www.Magellanassist.com](http://www.Magellanassist.com).

### **GENERAL ENROLLMENT GUIDELINES:**

Open Enrollment is from November 28, 2011 through December 16, 2011. Elections and changes made at this time will be effective for the January 1, 2012 through December 31, 2012 plan year. If you are making changes to your elections or are enrolling for the first time, it is imperative that you provide the necessary forms and/or documentation within this specified period. Dependent coverage may be lost and/or your desired changes will be denied if you do not provide documentation in a timely manner. The next opportunity for changes/updates being next year's Open Enrollment period. Early submission of your Open Enrollment requirements and forms is encouraged in order to ensure that all of your coverage information is updated / accurate prior to the January 1, 2012 plan year start date.

**During the City's annual Open Enrollment Period, eligible individuals may:**

- Keep your elections the same and do nothing (e.g., no enrollment forms needed). "Keeping your election the same" means that you:
  - a) Currently have Traditional or Direct Access coverage and you are NOT adding or dropping dependents;
  - b) Currently have Group Dental Health Administrators, Horizon Dental Option, or Horizon Dental Choice coverage and you are NOT adding or dropping dependents.
- Enroll themselves and their eligible dependents in the Benefit Plans. **Eligible dependent up to age 26 may be added to applicable plans during this open enrollment period. Financial dependence, residency with a parent, student status, marital status and employment may no longer be used to determine eligibility for coverage for any child up to age 26 under the City's current medical, prescription and Group Dental Health Administrators Plans.**
- Add eligible dependents to their coverage – in this case an enrollment form together with the required proof of relationship documents are required.
- Change from one Plan to another Plan – enrollment form needed along with proof of relationship documents for all dependents to be covered.
- Waive Coverage – Affidavits to waive coverage are available at the Employee Benefits Unit – City Hall - Room 211.
- Enroll eligible dependents under the provisions of Chapter 375 (continuation of coverage for dependents under 31 years of age.) – Visit the Employee Benefits Unit- City Hall – Room 211 for more information.

**Dropping of dependents is NOT a once a year event. It is your responsibility to notify the City if your dependent(s) no longer meets eligibility guidelines. Ineligible dependents will be terminated if deemed ineligible and/or if you do not provide proof of eligibility when requested by each carrier. Human Resources must be notified as soon as a dependent is ineligible in order that your dependents may preserve their right to continuation options.**

**IMPORTANT: It is your responsibility to ensure that your Open Enrollment changes, as well as all required Open Enrollment related documents (including acceptable proof of relationship documents) are submitted to the Employee Benefits Unit (City Hall Room 211) no later than 12/16/2011. Failure to submit the required proof of relationship documents will result in the non-enrollment of noted dependents but will not nullify the subscriber's enrollment in their plan selection.**

**IF ADDING A SPOUSE:** YOU MUST SUPPLY THE EMPLOYEE BENEFITS UNIT WITH YOUR ORIGINAL MARRIAGE CERTIFICATE WHICH IS ISSUED FROM THE MUNICIPALITY WHICH ISSUED YOUR MARRIAGE LICENSE.

**IF ADDING A CIVIL UNION PARTNER:** YOU MUST SUPPLY THE EMPLOYEE BENEFITS UNIT WITH YOUR ORIGINAL CIVIL UNION CERTIFICATE.

**IF ADDING A CHILD:** YOU MUST SUPPLY THE EMPLOYEE BENEFITS UNIT WITH YOUR DEPENDENTS' ORIGINAL BIRTH CERTIFICATE FROM THE MUNICIPALITY IN WHICH THE CHILD WAS BORN. IN CASES OF NATURAL CHILDREN, THE CERTIFICATE MUST LIST OUR EMPLOYEE AS A PARENT. IN CASES OF ADOPTED CHILDREN, WE WILL NEED TO MAKE A COPY OF THE ORIGINAL ADOPTION PAPERS. IN CASES OF STEP-CHILDREN, WE WILL NEED YOUR ORIGINAL MARRIAGE CERTIFICATE AS PROOF THAT YOU ARE MARRIED TO THE CHILD'S NATURAL PARENT, AS WELL AS THE CHILD'S ORIGINAL BIRTH CERTIFICATE (WHICH NOTES PARENT'S NAME) FROM THE MUNICIPALITY IN WHICH THE CHILD WAS BORN AS PROOF THAT THE CHILD WAS BORN TO YOUR SPOUSE. IN CASES WHERE YOU ARE AWARDED CUSTODY OF A CHILD NOT NATURALLY YOURS, ADOPTED OR A STEPCHILD, WE WILL NEED ORIGINAL COURT PAPERS GRANTING YOU CUSTODY.

**ADDITIONAL GUIDELINES OF WHICH YOU SHOULD BE MINDFUL THROUGHOUT THE PLAN YEAR.....**

- **New Dependents** – You have 60 days from the date of event (i.e. marriage, civil union, birth, adoption, etc) to add your newly eligible dependents. We recognize that in some cases subscribers may not be in receipt of the acceptable proof of relationship document within the 60 day notice period. In those instances, once you have submitted your timely enrollment change to the Employee Benefits Unit, you will be provided with a deadline for bringing in the proper proof of relationship document.
- **Divorce/Legal Separation** – Once a divorce/legal separation has been finalized the employee or retiree must notify the Employee Benefits Unit immediately to remove the ineligible dependent from his or her Benefit Plan(s). You must submit the completed change form(s) removing the ineligible spouse. **Failure to do so immediately will result in the assessment of costs to you, the employee/retiree.**
- **COBRA** – Upon eligible termination of coverage, you and your qualified family members may be eligible to continue coverage through the Consolidated Omnibus Reconciliation Act. Continuation coverage is at the subscriber's expense.
- **Waiving Coverage** – All employees and retirees have the option to waive any portion of their coverage. Affidavits to waive coverage are available at the Employee Benefits Unit – City Hall - Room 211.
- **Unpaid Leaves of Absence** – Employees who are on leaves of absence will remain covered for the first 90 days of their leave, then coverage will terminate. The employee will be offered an opportunity to continue coverage under COBRA.
- **Voluntary Plans** - We **strongly suggest** that employees on an unpaid leave of absence contact their voluntary plans (life insurance, short term disability, etc) regarding questions about satisfying their premium payments during this absence.

**Attention New Hires**

For new hires, the health benefits entitlements dates are as follows:

- Permanent Full-Time Employees: The first of the month following 30 days of employment.
- Provisional Full-Time Employees: The first of the month following 90 days of employment.
- School Crossing Guards: The first of the month following 90 days of employment.

Employees are encouraged to submit their health benefits enrollment forms to the Employee Benefits Unit (City Hall – Room 211) at least 3 weeks prior to their entitlement date. Please note that enrollment in the health plans is not automatic. Failure to enroll within a timely manner will make you ineligible and will constitute an automatic waiver of benefits until the next open enrollment period.

**Dependent Limiting Age**

Under the City's Medical, Prescription and Group Dental Health Administrators Plans, eligible dependents have the opportunity to be covered up to their 26th birthday.

Under the Horizon Dental Plans, eligible dependents have the opportunity to be covered through the end of the year in which their 19th or 23rd birthday occurs. The rules vary according to your union contract and particular class. This said, the general rules are as follows:

For non-uniformed employees Horizon Dental covers dependent children to the end of the year in which the 19th birthday occurs. If the dependent child is a full-time student and unmarried, Horizon Dental will extend coverage until the end of the year in which the 23rd birthday occurs.

***For management and many uniformed employees, Horizon Dental covers dependents though the end of the year in which the 23rd birthday occurs, as long as the dependents are unmarried and rely upon you for primary support.***

## **Important Reminders**

### **The City provides benefits with the below requirements being strictly adhered to:**

- You have 60 days to enroll your newly eligible dependent(s) under your coverage as a result of a qualifying event (marriage, civil union, birth or adoption of a child, etc.). Failure to enroll your newly eligible dependent(s) within the designated time requirement will make them ineligible for coverage until the next annual open enrollment period.
- Previously, the City of Newark informed you of the Under 31 Dependent Law issued by the State of New Jersey (P.L. 2005, c. 375). Chapter 375 enables eligible dependents under 31 who would otherwise lose coverage due to an age limit under the parent's group health plan to elect to continue coverage. This is to advise the City of Newark employees and retirees that your eligible dependent(s) may be entitled to elect coverage if they meet the following criteria: The child of the subscriber must be less than 31 years of age; unmarried; with no dependents of his/her own; either a resident of New Jersey or enrolled as a full-time student at an accredited institution of higher education; not covered under any other group or individual health benefits plan and not covered under Medicare; and the dependent must have previously aged out of their parent's group health plan. Election Period – Eligible dependents must make written election for coverage as follows: dependents who age-out of an in-force policy on or after May 12, 2006 may enroll as follows: within 30 days prior to the termination of coverage at the specific age in the policy; within 30 days after meeting the requirements for dependent status when coverage for the dependent under the policy previously terminated; or during an open enrollment period, as provided under the policy, if the dependent meets the requirements for dependent status during the open enrollment period. Coverage will be provided until the earliest of: The dependent's 31st birthday; the dependent no longer meets the eligibility criteria noted; the date on which the parent's coverage ceases for failure to make a timely premium payment; the date on which the parent's coverage as a covered employee/retiree ceases; the date on which the group plan terminates, or the date the employee's employer terminated participation under the group plan. It is the responsibility of the parent or continuing dependent to pay the full cost of the Chapter 375 coverage. You may obtain the enrollment application by contacting the carrier directly or by contacting the Employee Benefits Unit.
- A New Public Law, Michelle's Law, enacted on October 9, 2008 amends the Employee Retirement Income Security Act of 1974(ERISA), the Public Services Act, and the Internal Revenue Code. It is effective January 1, 2010 on your DA plan and as of June 1, 2010 on your Traditional plan. This new law prohibits a group health plan from terminating coverage of a dependent child due to a medically necessary leave of absence from, or any other change in enrollment at, a post secondary education institution that commences while such child is suffering from a serious illness or injury and that causes such child to lose student status for purposes of coverage under the plan, before the earlier of: (1) one year after the first day of the medically necessary leave of absence; or (2) the date on which such coverage would otherwise terminate under the terms of the plan. Written certification by the child's treating physician is required and is reviewed by the insurance carrier for eligibility.
- Health insurance fraud is a crime and can be pursued by the state criminally or civilly. Fraud can take various forms: fraud by physicians (billing carrier for services not rendered), fraud by subscribers (continuing coverage for ineligible individuals). Employees are required to immediately remove ineligible dependents (ex-spouse, married dependent child, etc.). The New Jersey Insurance Fraud Protection Act states that anyone who violates this act is subject to civil fines. This may not include any reimbursement owed to the City and/or carriers for claims paid and premium differentials.
- Please be sure to visit the Employee Benefits Unit if you need another copy of your benefit booklets.

## **PAYROLL DEDUCTIONS**

The 2012 bi-weekly payroll deduction for the individuals whose titles are governed by the following unions will be 1.5% of the salary which pension contribution salary is based (base salary plus longevity):

**AFCSME 2297** (Mechanics and Supervisors), **AFSCME 2298** (library employees), **AFSCME 2299** (Inspectors), **Attorneys** (formerly CWA), **Building Trades Bargaining Committee**, **Civil Service Association – Newark Council 21**, **JNESO, Local 68** (library employees), **NIOA** (Identification Officers), **SEIU 617** (Laborers), **SEIU 617** (Police Communication Clerks and Officers), **SEIU 617** (School Crossing Guards).

The 1.5% deduction will also apply to **Elected Officials** and **Management** employees.

**This 1.5% deduction will apply if you are enrolled in one or all of the following plan options (medical, dental or prescription).**

The 2011 bi-weekly deduction formula will be as follows:

*Annual base salary + longevity, times 1.5% and divided by 26 = bi-weekly payroll deduction.*

**The conditions set forth herein shall not be applicable to employees who are covered by a ratified bargaining union agreement (see union list below):**

**Fraternal Order of Police (FOP), Superior Officers Association (SOA), Newark Deputy Police Chief Association (NDPCA), Newark Firefighter Union (NFU), and NFOU (Fire Officers).**