HB-0327-1105p

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

1. Date of this certificate: _____
2. Name of participant: _____
3. Name of group health plan: _____
4. Identification number of participant: _____
5. Name of any dependents to whom this certificate applies: _____

   _____
6. Name, address, and telephone number of issuer responsible for providing this certificate:

   _____

   _____

   _____

   _____
7. For further information, call: _____
8. If the individual(s) identified in line 2 and line 5 has at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here _____ and skip lines 9 and 10.
9. Date waiting period or affiliation period (if any) began: _____
10. Date coverage began: _____
11. Date coverage ended: _____
    (or check if coverage is continuing as of the date of this certificate _____).

NOTE: *Separate certificates will be furnished if information is not identical for the participant and each covered dependent.*

Statement of HIPAA Portability Rights

IMPORTANT - KEEP THIS CERTIFICATE. This certificate is being provided to you in compliance with the requirements of the Federal Health Insurance Portability and Accounting Act (HIPAA) of 1996. It provides evidence of your prior health coverage in the New Jersey State Health Benefits Program.You may need to furnish this certificate to your new insurer if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the 6-month period prior to your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

Preexisting Condition Exclusions — Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." A preexisting condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or — if there is a waiting period — the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

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Statement of HIPAA Portability Rights (Continued)

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including: group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

- Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan.

Right to Get Special Enrollment in Another Plan — Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition Against Discrimination Based on a Health Factor — Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to Individual Health Coverage — Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

- Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

State Flexibility — This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For More Information — If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the federal Centers for Medicare and Medicaid Services publication hotline at 1-800-633-4227 (ask for *Protecting Your Health Insurance Coverage*). These publications and other useful information are also available on the Internet at: *www.dol.gov/ebsa,* the DOL's interactive Web pages - Health E-laws, or at: *www.cms.hhs.gov/hipaa1*.

INSTRUCTIONS FOR COMPLETING THE HIPAA CERTIFICATE OF COVERAGE

The completion of a *Certificate of Coverage* is a requirement of the federal Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires that group health plans provide a *Certificate of Coverage* automatically to any covered employee or dependent who loses group coverage after June 1, 1997. HIPAA also requires that individuals covered by a group plan who lost coverage between June 1, 1996 and June 1, 1997 be provided a *Certificate of Coverage* upon request of that individual or his/her designated agent (e.g., new group insurance provider). **In the SHBP, the participating local employer or State payroll office has the responsibility for providing required *Certificates of Coverage*.**

ITEM 1: Insert the date you are completing the form.

ITEM 2: Insert the full name of the covered participant requesting the *Certificate of Coverage*.

ITEM 3: Insert the name of the SHBP health plan that covered the participant.

ITEM 4: Insert the participant's SHBP health coverage identification number.

ITEM 5: Insert the full name(s) of any dependent(s) covered under the participant's health coverage at the time of termination of coverage. Indicate any dependent(s) who did not have coverage for the same time period as the participant. For example, if the participant was covered for over 18 months, but the dependent(s) was only covered for eight months, indicate that on the form.

ITEM 6: In most cases, the name, address, and phone number of the employer issuing the certificate will be inserted here. If the *Certificate of Coverage* is being issued subsequent to the termination of coverage under COBRA, the SHBP's COBRA Administrator will complete this form and insert its identifying information here.

ITEM 7: Insert the same telephone number indicated in Item 6.

ITEM 8: Show the period of time for which the participant is entitled to credit under his/her new plan's pre-existing condition exclusion provisions (if any). This includes the period of time the participant was covered under the SHBP plan, either as an active employee or on any other basis, including COBRA. If the participant went 63 or more consecutive days without health coverage, any coverage that the participant had before the significant break in coverage is ignored. A waiting period before an employee is eligible for plan coverage does not count either as part of a significant break in coverage or in an individual's total of creditable coverage. You must also show the period of coverage for dependent(s) if different from the participant. Do this in Item 4. The longest pre-existing condition period under HIPAA is 18 months, therefore if the participant was covered by a SHBP plan for at least 18 months, that is all that needs to be reported here. If the coverage period was shorter than 18 months, the following must be reported in Items 9 through 11:

- the first day of the waiting period completed by the participant, if any (this is the period between the date of hire and the start of coverage);
- the first day of the participant's creditable coverage;
- the last day of the participant's creditable coverage.

ITEM 9: Insert the day the waiting period (if any) began. This would be the first day at work for a new employee whose coverage does not start immediately.

ITEM 10: Insert the date coverage began.

ITEM 11: Insert the date coverage ended. If you have confirmation that coverage under COBRA or the SHBP Retired Group is continuing, then check the coverage continuing block. Do not check the coverage continuing block if you are not certain that a COBRA or Retired Group application has been initiated and the enrollment processed.