SALEM COUNTY IMPROVEMENT AUTHORITY

RESOLUTION 2015-61

November 12, 2015

RESOLUTION SETTING HEALTHCARE WAIVER COMPENSATION FOR CY 2016

WHEREAS, the SCIA re-entered the State Health Benefit Plan (“SHBP”) in December 2011 for health benefits for its employees, and

WHEREAS, the SHBP requires all employees who are qualified and choose to waive their health benefits to file the health benefit waivers for the coming year at the time of open enrollment; and

WHEREAS, the SHBP and SCIA Policy permits an employee to waive health benefits coverage under the SHBP pursuant to Chapter 92, P.L. 2007 and Chapter 2, P.L. 2010; and

WHEREAS, Chapter 92, P.L. 2007 and Chapter 2, P.L. 2010 permits an employer to compensate an employee for a certain portion of the health benefits costs saved by such waiver (not to exceed 25% of the expense saved or $5,000 whichever is lower);

NOW THEREFORE, BE IT RESOLVED by the SCIA as follows:

1. Any full-time employee of the SCIA, otherwise eligible for health benefits under a private self funded plan or as a dependent of another eligible participant in the SHBP/SEHB, shall be permitted to waive health benefits coverage provided to that employee by the SCIA. Any full-time employee waiving such coverage for the CY 2016, who is eligible for compensation, shall be paid an amount equal to 25% of the actual costs saved by SCIA (based on the AETNA 15 plan for ‘employee only’ medical and prescription coverage-after the employee contribution is deducted) for the healthcare waiver based on the value of the benefit in effect at the time the initial waiver is made, except that in no event shall such employee be paid an amount in excess of $5,000.00 and no annual increase adjustment will be made in the waiver amount from year to year.

2. The compensation for such waiver by an employee shall be paid in a separate check in addition to such employee’s base salary. Said payment shall be made on or about December 31, 2016. In the event such employee seeks health care benefits through the SCIA during CY 2016 after initially waiving his/her right to health care benefits earlier in the year, said employee shall not be eligible for any compensation whatsoever for any period of time in CY 2016.

3. To be eligible for compensation for any waiver hereunder, the employee shall first be required to provide SCIA with written proof of alternate medical or health care insurance coverage.

4. Employees are not eligible for the waiver incentive (payment) if their other coverage is with the SHBP or SEHB.
5. In addition, any employee who wishes to waive healthcare coverage shall submit a written waiver during the open enrollment period. The written waiver shall be submitted to the SCIA Executive Director.

6. Payment of any such health care waiver compensation shall be subject to the terms of any Collective Bargaining Agreement to which such employee is subject, if any.

Michael Brooks, Secretary

Robert Widdifield, Chairman

I hereby certify the above to be a true copy of a resolution adopted by the SCIA at a regular meeting held on November 12, 2015.

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

COVERAGE WAIVER/REINSTATMENT
FOR LOCAL GOVERNMENT/EDUCATIONAL EMPLOYEES
STATE HEALTH BENEFITS PROGRAM
SCHOOL EMPLOYEES’ HEALTH BENEFITS PROGRAM

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

1. Name Donald F Youngblood

Check one box below.

Waiver of Coverage

In accordance with Chapter 92, P.L. 2007 and Chapter 2, P.L. 2010, I have agreed to waive coverage (medical and, if applicable, prescription drug coverage) with the State Health Benefits Program (SHBP) or School Employees’ Health Benefits Program (SEHB) to which I am entitled because I am covered under other health coverage. I understand that I am not eligible for the waiver incentive if my other coverage is with the SHBP or SEHB. (Note: You must submit proof of the other health coverage to your employer along with this form.)

In place of health benefit coverage, my employer will pay me the amount shown in Par. 2 below. I understand that I may resume SHBP or SEHB coverage when I am no longer covered by the other health coverage, provided that I notify the Health benefits Bureau within 60 days of the loss of the other coverage and provide proof of loss of that coverage.

Reinstatement of Coverage

I previously waived SHBP or SEHB coverage because I had other health coverage.

As of ______________ (date), I am no longer covered by the other health plan, request reinstatement of health benefits coverage with the SHBP or SEHB, and have provided proof of loss of the other coverage. I further understand that coverage is permitted as an employee, retiree, or dependent, however, multiple coverage under the SHBP or SEHB is prohibited.

Employee’s Signature Donald F Youngblood Date 10-12-15

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

We will pay the above employee $______________ every ______________ in place of providing State Health Benefits Program or School Employees’ Health Benefits Program coverage. We understand that this payment may not be more than 25% of the amount saved by the employer because of the waiver or $5,000, whichever is less.

We request reinstatement of this employee’s State Health Benefits Program or School Employees’ Health Benefits Program coverage.

A completed Health Benefits Program Application must be attached to either a waiver or a reinstatement. If the application for waiver is received by the Health Benefits Bureau by the 5th of the month, the change will take place on the first of the following month. 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 Salem County Improvement SHBP/SEHB Location # 78000

Signature of Certifying Officer Anne Barton Date 11-3-15
STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS
PO BOX 299
TRENTON, NJ 08625-0299

COVERAGE WAIVER/REINSTATEMENT
FOR LOCAL GOVERNMENT/EDUCATIONAL EMPLOYEES
STATE HEALTH BENEFITS PROGRAM
SCHOOL EMPLOYEES’ HEALTH BENEFITS PROGRAM

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

1. Name Robert A Nogjen
   SS#  [redacted]

Check one box below.

☒ Waiver of Coverage
In accordance with Chapter 92, P.L. 2007 and Chapter 2, P.L. 2010, I have agreed to waive coverage (medical and, if applicable, prescription drug coverage) with the State Health Benefits Program (SHBP) or School Employees’ Health Benefits Program (SEHBP) to which I am entitled because I am covered under other health coverage. I understand that I am not eligible for the waiver incentive if my other coverage is with the SHBP or SEHBP. (Note: You must submit proof of the other health coverage to your employer along with this form.)

In place of health benefit coverage, my employer will pay me the amount shown in Part 2 below. I understand that I may resume SHBP or SEHBP coverage when I am no longer covered by the other health coverage, provided that I notify the Health benefits Bureau within 60 days of the loss of the other coverage and provide proof of loss of that coverage.

☐ Reinstatement of Coverage
I previously waived SHBP or SEHBP coverage because I had other health coverage.

As of ____________, __________________________ (date), I am no longer covered by the other health plan, request reinstatement of health benefits coverage with the SHBP or SEHBP, and have provided proof of loss of the other coverage. I further understand that coverage is permitted as an employee, retiree, or dependent, however, multiple coverage under the SHBP or SEHBP is prohibited.

Employee’s Signature Robert A Nogjen  Date 11-9-15

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

☐ We will pay the above employee $ 801.00 in place of providing State Health Benefits Program or School Employees’ Health Benefits Program coverage. We understand that this payment may not be more than 25% of the amount saved by the employer because of the waiver or $5,000, whichever is less.

☐ We request reinstatement of this employee's State Health Benefits Program or School Employees’ Health Benefits Program coverage.

A completed Health Benefits Program Application must be attached to either a waiver or a reinstatement. If the application for waiver is received by the Health Benefits Bureau by the 5th of the month, the change will take place on the first of the following month. 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 Salem County Improvement Authority  SHBP/SEHBP Location # 174000
Signature of Certifying Officer Cassie Stanton  Date 11-3-15
STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS
PO BOX 299
TRENTON, NJ 08625-0299

COVERAGE WAIVER/REINSTATEMENT
FOR LOCAL GOVERNMENT/EDUCATIONAL EMPLOYEES
STATE HEALTH BENEFITS PROGRAM
SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM

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

1. Name ___________________ SS# ___________________

Check one box below.

☑ Waiver of Coverage
In accordance with Chapter 92, P.L. 2007 and Chapter 2, P.L. 2010, I have agreed to waive coverage (medical and, if applicable, prescription drug coverage) with the State Health Benefits Program (SHBP) or School Employees' Health Benefits Program (SEHB) to which I am entitled because I am covered under other health coverage. I understand that I am not eligible for the waiver incentive if my other coverage is with the SHBP or SEHB. (Note: You must submit proof of the other health coverage to your employer along with this form.)

In place of health benefit coverage, my employer will pay me the amount shown in Part 2 below. I understand that I may resume SHBP or SEHB coverage when I am no longer covered by the other health coverage, provided that I notify the Health benefits Bureau within 60 days of the loss of the other coverage and provide proof of loss of that coverage.

☐ Reinstatement of Coverage
I previously waived SHBP or SEHB coverage because I had other health coverage.

As of _________________ (date), I am no longer covered by the other health plan, request reinstatement of health benefits coverage with the SHBP or SEHB, and have provided proof of loss of the other coverage. I further understand that coverage is permitted as an employee, retiree, or dependent, however, multiple coverage under the SHBP or SEHB is prohibited.

Employee's Signature ___________________ Date ___________________

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

☐ We will pay the above employee $ ___________________ for _______________ in place of providing State Health Benefits Program or School Employees' Health Benefits Program coverage. We understand that this payment may not be more than 25% of the amount saved by the employer because of the waiver or $5,000, whichever is less.

☐ We request reinstatement of this employee's State Health Benefits Program or School Employees' Health Benefits Program coverage.

A completed Health Benefits Program Application must be attached to either a waiver or a reinstatement. If the application for waiver is received by the Health Benefits Bureau by the 5th of the month, the change will take place on the first of the following month. 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/SEHB Location # _______

Signature of Certifying Officer ___________________ Date _______________
STATE OF NEW JERSEY  
DEPARTMENT OF THE TREASURY  
DIVISION OF PENSIONS AND BENEFITS  
PO BOX 299  
TRENTON, NJ 08625-0299

COVERAGE WAIVER/REINSTATEMENT  
FOR LOCAL GOVERNMENT/EDUCATIONAL EMPLOYEES  
STATE HEALTH BENEFITS PROGRAM  
SCHOOL EMPLOYEES’ HEALTH BENEFITS PROGRAM

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

1. Name ____________________________ SS# ____________________

Check one box below.

☐ Waiver of Coverage

In accordance with Chapter 92, P.L. 2007 and Chapter 2, P.L. 2010, I have agreed to waive coverage (medical and, if applicable, prescription drug coverage) with the State Health Benefits Program (SHBP) or School Employees’ Health Benefits Program (SEHB) to which I am entitled because I am covered under other health coverage. I understand that I am not eligible for the waiver incentive if my other coverage is with the SHBP or SEHB. (Note: You must submit proof of the other health coverage to your employer along with this form.)

In place of health benefit coverage, my employer will pay me the amount shown in Part 2 below. I understand that I may resume SHBP or SEHB coverage when I am no longer covered by the other health coverage, provided that I notify the Health benefits Bureau within 60 days of the loss of the other coverage and provide proof of loss of that coverage.

☐ Reinstatement of Coverage

I previously waived SHBP or SEHB coverage because I had other health coverage.

As of __________, I am no longer covered by the other health plan, request reinstatement of health benefits with the SHBP or SEHB, and have provided proof of loss of the other coverage. I further understand that coverage is permitted as an employee, retiree, or dependent, however, multiple coverage under the SHBP or SEHB is prohibited.

Employee’s Signature ____________________________ Date ____________

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

☐ We will pay the above employee $ _______ for ____________ in place of providing State Health Benefits Program or School Employees’ Health Benefits Program coverage. We understand that this payment may not be more than 25% of the amount saved by the employer because of the waiver or $5,000, whichever is less.

☐ We request reinstatement of this employee’s State Health Benefits Program or School Employees’ Health Benefits Program coverage.

A completed Health Benefits Program Application must be attached to either a waiver or a reinstatement. If the application for waiver is received by the Health Benefits Bureau by the 5th of the month, the change will take place on the first of the following month. 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/SEHB Location # ____________

Signature of Certifying Officer ____________________________ Date ____________
COVERAGE WAIVER/REINSTATEMENT
FOR LOCAL GOVERNMENT/EDUCATIONAL EMPLOYEES
STATE HEALTH BENEFITS PROGRAM
SCHOOL EMPLOYEES’ HEALTH BENEFITS PROGRAM

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

1. Name MEUNDA J. WILLIAMS

Check one box below.

☒ Waiver of Coverage
In accordance with Chapter 92, P.L. 2007 and Chapter 2, P.L. 2010, I have agreed to waive coverage (medical and, if applicable, prescription drug coverage) with the State Health Benefits Program (SHBP) or School Employees’ Health Benefits Program (SEHBP) to which I am entitled because I am covered under other health coverage. I understand that I am not eligible for the waiver incentive if my other coverage is with the SHBP or SEHBP. (Note: You must submit proof of the other health coverage to your employer along with this form.)

In place of health benefit coverage, my employer will pay me the amount shown in Part 2 below. I understand that I may resume SHBP or SEHBP coverage when I am no longer covered by the other health coverage, provided that I notify the Health benefits Bureau within 60 days of the loss of the other coverage and provide proof of loss of that coverage.

☐ Reinstatement of Coverage
I previously waived SHBP or SEHBP coverage because I had other health coverage.

As of ___________, I am no longer covered by the other health plan, request reinstatement of health benefits coverage with the SHBP or SEHBP, and have provided proof of loss of the other coverage. I further understand that coverage is permitted as an employee, retiree, or dependent, however, multiple coverage under the SHBP or SEHBP is prohibited.

Employee’s Signature MEUNDA J. WILLIAMS
Date 10/17/15

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

☐ We will pay the above employee $ ___________ every 01/16 in place of providing State Health Benefits Program or School Employees’ Health Benefits Program coverage. We understand that this payment may not be more than 25% of the amount saved by the employer because of the waiver or $5,000, whichever is less.

☐ We request reinstatement of this employee’s State Health Benefits Program or School Employees’ Health Benefits Program coverage.

A completed Health Benefits Program Application must be attached to either a waiver or a reinstatement. If the application for waiver is received by the Health Benefits Bureau by the 5th of the month, the change will take place on the first of the following month. 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 SALISBURY TOWNSHIP, SPECIAL DISTRICT
SHBP/SEHBP Location #

Signature of Certifying Officer MEUNDA J. WILLIAMS
Date 11/3/15