

17:9-1.3 Appeals from Commission decisions

The following statement shall be incorporated in every written notice setting forth the Commission's determination

in a matter where such determination is contrary to the claim made by the claimant or his legal representative:

"If you disagree with the determination of the Commission in this matter, you may appeal by sending a written statement to the Commission within 45 days from the date of this letter, informing the Commission of your disagreement and all of the reasons therefor. If no such written statement is received within the 45 day period, this determination shall be considered final."

As amended, R.1970 d.147, effective December 10, 1970.
See: 2 N.J.R. 94(d), 3 N.J.R. 11(a).

Case Notes

Where the Commission has not exercised authority to regulate mental illness coverage, the Appellate Division would not defer to the Health Benefits' Commission's interpretation. *Heaton v. State Health Benefits Com'n*, 264 N.J.Super. 141, 624 A.2d 69 (A.D.1993).

Administrative remedies must be exhausted by appealing health insurance administrators' adverse determination before commencing suit against the administrator. *Burley v. Prudential Ins. Co. of America*, 251 N.J.Super. 493, 598 A.2d 936 (A.D.1991).

17:9-1.4 (Reserved)

As amended, R.1971 d.21, effective February 17, 1971.
See: 3 N.J.R. 10(a), 3 N.J.R. 52(c).
As amended, R.1979 d.159, effective April 23, 1979.
See: 11 N.J.R. 94(d), 11 N.J.R. 304(c).
As amended, R.1983 d.44, effective March 7, 1983.
See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).

This section formerly contained rules on local employer premium and interest.

17:9-1.5 Voluntary termination of employer; notice

(a) A resolution furnished by the Division of Pensions must be completed by employers who wish to voluntarily terminate their participation in the program.

(b) For purposes of local coverage, when a participating employer voluntarily terminates coverage, the coverage for the employer's active and retired employees shall terminate as of the first of the month following a 60-day period beginning with the receipt of the resolution by the Health Benefits Commission. The Commission may, from time to time, establish a re-entry application period not to exceed 30 days for those employers who have terminated coverage. During this period, an employer who has terminated coverage only once may submit a resolution for automatic re-entry. The re-entry shall be effective upon a date set by the Commission which date shall be not less than 60 days nor more than 365 days following the receipt of the resolution for re-entry. Automatic re-entry into the program will be permitted only once.

1. An employer who has terminated coverage more than once may submit a resolution for re-entry during the re-entry application period. The Commission shall consider the relevant facts accompanying the resolution, including any hardship or emergency, the impact of re-entry on the program and individual members, and whether re-entry is consistent with statutory law or judicial determinations. The Commission shall approve or disapprove the resolution for re-entry and shall so notify the employ-

er within 30 days following receipt of the resolution. If the Commission approves the re-entry, the re-entry shall be effective upon a date determined by the Commission, which date shall be not less than 60 days nor more than 365 days following the Commission's approval. The re-entry shall be contingent upon the employer's reimbursement to the Commission of administrative expenses reasonably based upon the approximate cost to the Commission of re-enrolling the employer.

(c) The employer shall notify all active employees of the date their coverage in the program has terminated.

(d) The Division of Pensions shall act to notify all retired employees or survivors of the termination of coverage and to send a list of the names and addresses to the terminating employer for his or her information, upon his or her request.

Amended by R.1970 d.147, effective December 10, 1970.
See: 2 N.J.R. 94(d), 3 N.J.R. 11(a).
Amended by R.1976 d.124, effective April 22, 1976.
See: 8 N.J.R. 85(c), 8 N.J.R. 263(a).
Amended by R.1983 d.332, effective August 15, 1983.
See: 15 N.J.R. 793(a), 15 N.J.R. 1383(d).

List of names and addresses to be sent to terminating employer upon request.

Amended by R.1985 d.587, effective November 18, 1985.
See: 17 N.J.R. 1399(a), 17 N.J.R. 2784(b).

(b): Added text "for a period . . . permitted only once."
Amended by R.1993 d.269, effective June 7, 1993.
See: 25 N.J.R. 460(a), 25 N.J.R. 2505(d).

17:9-1.6 Default of employer; notice

(a) For purposes of local coverage, a participating employer will be considered in default 31 days after the beginning of the coverage period for which charges were due. At that point, coverage will terminate for all employers and their dependents covered by the employer.

(b) The secretary of the commission will notify the Attorney General's office, the Division of Local Finance, the Department of Education and the carriers. The Division of Pensions will notify every participating employee, active and retired, or survivors, of the termination of coverage.

As amended, R.1970 d.147, effective December 10, 1970.
See: 2 N.J.R. 94(d), 3 N.J.R. 11(a).
As amended, R.1983 d.44, effective March 7, 1983.
See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).

The word "premiums" was changed to "charges" and the phrase "his" to "his or her".

17:9-1.7 Guidelines; local employers; purchase of contracts

Pursuant to the provisions of N.J.S.A. 52:14-17.25 et seq., it is the policy of the State Health Benefits Commission that when local governments purchase insurance contracts of health benefits, such as prescription drug, dental expense and vision care coverages, such contracts and coverage therein must adhere to the guidelines approved by the State Health Benefits Commission for such contracts or coverag-

es, as such guidelines were transmitted to all public employers by the Division of Pensions. Local governments cannot deviate from such guidelines in purchasing such contracts or coverages without the approval of the State Health Benefits Commission.

As amended, R.1983 d.331, effective August 15, 1983.
See: 15 N.J.R. 884(a), 15 N.J.R. 1383(e).

17:9-1.8 Employer incentives for non-enrollment prohibited

An employer shall not offer a financial enticement of cash or anything else of value to an employee who elects not to enroll or to terminate enrollment in the State Health Benefits Program.

17:9-1.9 Definitions

The following words and terms, when used in this chapter, shall have the following meaning, unless the context clearly indicates otherwise:

“Act” means the New Jersey State Health Benefits Program Act, P.L. 1961, c.49 (N.J.S.A. 52:14-17.25 et seq.), as amended and supplemented.

“Base salary” means an employee’s annual base salary as of the first pay period of the calendar year for Federal and State income taxes.

“Category of coverage” means one of the options used for determining the rates for the premium or periodic charges for different levels of coverage under the program which include single, husband and wife, parent and child, and family coverage, with and without Medicare.

“Commission” means the State Health Benefits Commission created by Section 3 (N.J.S.A. 52:14-17.27) of the Act.

“NJ PLUS” is the name of the State managed care plan as defined in Section 2 (N.J.S.A. 52:14-17.26) of the Act.

“Participating HMO” means a health maintenance organization duly authorized to operate in the State which is under contract with the Commission to participate in the program.

“State bi-weekly sub-group” means a State payroll location or employment unit which reports to the program on a bi-weekly basis.

“State monthly sub-group” means a State payroll location or employment unit which reports to the program on a monthly basis.

New Rule, R.1996 d.298, effective June 17, 1996.
See: 28 N.J.R. 1944(a), 28 N.J.R. 3171(a).

SUBCHAPTER 2. COVERAGE

17:9-2.1 Enrollment charges

Each eligible employee shall be eligible to enroll for coverage without cost to the employee; and each employee’s eligible dependents shall be eligible for enrollment for coverage provided that the additional charges for such coverage shall be paid by the employee as required by his or her employer.

As amended, R.1983 d.44, effective March 7, 1983.
See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).

The word “premiums” was changed to “charges” and “his” to “his or her”.

17:9-2.2 Enrollment form

At the time each employee first becomes eligible for coverage, the employee shall complete enrollment and authorization forms indicating the employee’s election to enroll or not to enroll for coverage on his or her own behalf; and the employee’s election to enroll or not to enroll his or her dependents for coverage under one of the options to be provided in the commission’s master contract or contracts.

As amended, R.1983 d.44, effective March 7, 1983.
See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).

Added reference to female employees.

17:9-2.3 Annual enrollment period

(a) Any employee who shall elect not to enroll for coverage for himself or herself or for his or her dependent at the time such employee or dependent first becomes eligible for coverage shall subsequently be permitted to enroll himself or herself and his or her dependents only during the annual enrollment period, which is the month of April of each year with coverage effective for the first coverage period in July in the case of State coverage and the month of March with coverage effective July 1 in the case of local coverage.

(b) The annual enrollment period will be the annual opportunity for employees to elect participation in a health maintenance organization for themselves and their dependents. The change in the election cannot be made more frequently than once a year except where the employee moves and is no longer able to be serviced by a health maintenance organization or the health maintenance organization is terminated.

(c) The State Health Benefits Commission may, at its discretion in order to optimize benefits, establish a special enrollment period at any time it deems necessary to do so.

Amended by R.1974 d.228, effective August 19, 1974.
See: 6 N.J.R. 156(a), 6 N.J.R. 360(c).
Amended by R.1976 d.124, effective April 22, 1976.
See: 8 N.J.R. 85(c), 8 N.J.R. 263(a).
Amended by R.1978 d.131, effective April 18, 1978.
See: 10 N.J.R. 80(b), 10 N.J.R. 265(b).
Amended by R.1978 d.442, effective December 26, 1978.
See: 10 N.J.R. 456(a), 11 N.J.R. 105(b).
Amended by R.1983 d.44, effective March 7, 1983.

See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).

The word "his" was changed to "his or her".

Amended by R.1985 d.18, effective February 4, 1985.

See: 16 N.J.R. 2422(a), 17 N.J.R. 320(b).

(c) added.

Amended by R.1993 d.259, effective June 7, 1993.

See: 25 N.J.R. 4025(a), 25 N.J.R. 2506(a).

17:9-2.4 Coverage changes; exceptions

(a) An employee may change his or her enrollment and the enrollment of his or her dependents to any type of coverage at any time if such changes result from a change in family, dependency or employment status of the employee or his or her dependents. Such changes will be permitted under the following conditions:

1. *Marriage.* Any employee who has been enrolled for coverage and who subsequently marries may enroll the spouse and eligible dependents, if any, for any appropriate type of coverage by completing and forwarding a new enrollment form within the period beginning 60 days prior to the marriage and ending 60 days after such marriage. In the event that the spouse of such employee is already

enrolled as an employee, the provisions of N.J.A.C. 17:9-3.9 shall apply to such spouse's enrollment.

2. *Divorce; separation.* Any employee who has been enrolled or has been covered as a dependent of an enrolled employee and is subsequently divorced may enroll, delete from coverage or cover any eligible dependents by completing and forwarding a new enrollment form within 60 calendar days after the divorce of such employee or dependent of an employee who was covered previously under the spouse's contract. A change of enrollment of this nature is optional in the case of separation.

3. *Death of spouse or dependent child.* Any employee, who is enrolled as the dependent of another employee who dies, may thereupon enroll as an employee, and may enroll any eligible dependents, for any appropriate coverage by completing and forwarding a new enrollment form within 60 days following the death. Any employee may, upon the death of a spouse or dependent child who is enrolled as a dependent, enroll himself or herself and any other eligible dependents for any appropriate coverage by completing and forwarding a new enrollment form.

(g) The definition of "retired employee" shall not include an employee who on cessation of employment, elects a vested, deferred retirement benefit under which payments begin at a future date.

(h) The employer liability for charge payments on behalf of eligible retired employees which includes those employees who are eligible to receive long-term disability benefits is payable in accordance with the provisions of N.J.S.A. 52:14-17.32 and 17.38.

As amended, R.1973 d.8, eff. Jan. 4, 1973.

See: 4 N.J.R. 282(a), 5 N.J.R. 59(b).

As amended, R.1978 d.130, eff. April 8, 1978.

See: 9 N.J.R. 600(a), 10 N.J.R. 265(a).

As amended, R.1978 d.442, eff. December 26, 1978.

See: 10 N.J.R. 456(a), 11 N.J.R. 105(b).

As amended, R.1983 d.44, eff. March 7, 1983.

See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).

The word "premium" was changed to "charge" and reference to female employees was added.

Amended by R.1985 d.676, effective January 21, 1986.

See: 17 N.J.R. 2386(a), 18 N.J.R. 212(b).

New (e) added; old (e)-(f) recodified (f)-(g).

Amended by R.1986 d.423, effective October 20, 1986.

See: 18 N.J.R. 1451(b), 18 N.J.R. 2135(c).

Added text to (a) "This retired employee . . . of such employer"; deleted text from (b) "and immediately applies . . . system or plan".

Amended by R.1987 d.497, effective December 7, 1987.

See: 19 N.J.R. 1636(b), 19 N.J.R. 2303(b).

Substantially amended.

Amended by R.1988 d.470, effective October 3, 1988.

See: 20 N.J.R. 1182(a), 20 N.J.R. 2467(b).

Deleted "covered" from (a) and added "eligible for coverage . . . participate under P.L. 1987, c.384".

17:9-6.2 Coverage for prospective retirants

(a) For purposes of retired coverage, continuity of coverage may be extended until such time as the application for retirement is formally approved by the Board of Trustees of the retirement system paying the benefit or by the carrier underwriting the individual annuity contracts.

1. If it is not necessary for a Board of Trustees to approve the application, then the retirement application will be considered approved when the necessary action has been taken by the Division of Pensions, the local retirement system, or the carrier.

2. The retiring employee or eligible dependent of a retired employee must submit personal payments to the Health Benefits program in order to continue coverage.

3. Should coverage lapse through no fault of the retired employee of his or her spouse who would be eligible to continue such coverage, retroactive coverage may be granted, provided charges are received.

(b) Any employee, upon retirement, or an eligible survivor of such employee will be notified by regular mail of his or her right to continuous coverage in the State Health Benefits Program. The retired employee or eligible survivor must, within a 15-day period following the receipt of the letter offering retired coverage, submit the appropriate application and charges for such coverage, if required. Any retired employee or eligible survivor not responding within the 15-day period shall receive a second notice by certified mail.

As amended, R.1973 d.8, eff. Jan. 4, 1973.

See: 4 N.J.R. 282(a), 5 N.J.R. 59(b).

As amended, R.1983 d.44, eff. March 7, 1983.

See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).

The word "premiums" was changed to "charges" and "his" to "his or her".

Amended by R.1985 d.677, effective January 21, 1986.

See: 17 N.J.R. 2604(a), 18 N.J.R. 213(a).

Text added in (b) "Any retired employee . . . by certified mail."

17:9-6.3 Retired coverage; limitation

(a) For purposes of retired coverage, coverage may be increased to include a spouse and dependents acquired subsequent to the date of retirement. In all other instances, coverage cannot be increased.

(b) Pensioners, whose original retirement allowance or pension is less than the charge to be deducted to pay for the cost of the coverage to such pensioner, will be permitted to continue coverage provided that the pensioner pays for the cost of such coverage in advance on a quarterly basis, in which case there will be no pension deduction.

(c) If the pensioner moves and is no longer able to be serviced by a health maintenance organization or the organization is terminated, the pensioner will have a 30-day period for the selection of coverage under another participating organization or the traditional coverage.

(d) A pensioner and/or spouse, who has maintained coverage in the State Health Benefits Program following retirement and is subsequently removed from such coverage for not having the complete Federal Medicare coverage Parts A and B as required by statute, will be permitted to obtain prospective reentry into the State Health Benefits Program once proof of complete Federal Medicare coverage Part A and B has been provided to the Division of Pensions.

(e) Coverage for a retired employee or the spouse of a retired employee of an employer who becomes a participating employer in the State Health Benefits Program shall be limited to that which is comparable to the coverage which the employer or spouse had under the group medical insurance plan of the employer immediately prior to the date the employer became a participating employer.

As amended, R.1975 d.159, effective June 9, 1975.

See: 7 N.J.R. 118(e), 7 N.J.R. 349(b).

As amended, R.1976 d.313, effective October 8, 1976.

See: 8 N.J.R. 443(c), 8 N.J.R. 539(a).

As amended, R.1983 d.44, effective March 7, 1983.

See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).

Subsection (d) concerning prospective reentry into the State Health Benefits Program, added.

Amended by R.1985 d.165, effective April 1, 1985.

See: 16 N.J.R. 3192(b), 17 N.J.R. 841(a).

(a)-(b) substantially amended.

Amended by R.1985 d.676, effective January 21, 1986.

See: 17 N.J.R. 2386(a), 18 N.J.R. 212(b).

(e) added.

Case Notes

Retiree who elected not to participate in state health plan at time he retired could not later enroll. *Driller v. State Health Benefits Commission*. 93 N.J.A.R.2d (TYP) 16.

17:9-6.4 Disability earnings

A retirant, whose disability retirement allowance has been suspended as his or her income exceeded the limits established by law, shall have his or her health insurance terminated upon the suspension of his or her allowance. Upon the reinstatement of the individual's allowance, his or her coverage will resume on a prospective basis only. However, where the employer is liable for the charge payment, the coverage shall be continued without interruption.

R.1976 d.313, eff. October 8, 1976.
See: 8 N.J.R. 443(c), 8 N.J.R. 539(a).
As amended, R.1983 d.44, eff. March 7, 1983.
See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).

Reference to premiums was changed to charges and reference to female employees added.

17:9-6.5 Discontinuance of allowance

When a retirant, beneficiary or their designated representative fails to furnish information which results in the discontinuance of the allowance, the retirant's or beneficiary's coverage may be terminated upon such discontinuance. However, where the employer is liable for the charge payment, the coverage shall be continued without interruption. Upon the reinstatement of the individual's retirement allowance, his or her health insurance will be resumed and may be made retroactive. The same applies whenever an allowance is discontinued such as in cases involving possible incompetency, change of guardian or other arrangements which may temporarily cause the suspension of the payment.

R.1976 d.313, eff. October 8, 1976.
See: 8 N.J.R. 443(c), 8 N.J.R. 539(a).
As amended, R.1983 d.44, eff. March 7, 1983.
See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).

The word "premium" was changed to "charge" and "his" to "his or her".

17:9-6.6 Beneficiary, dependent or survivor

(a) An eligible beneficiary or survivor will have their coverage discontinued upon the death of the retirant but will be given the opportunity to continue coverage on a prospective basis only, once they have filed proper applications for pensions. Coverage may be made retroactive for as much as six months provided the necessary charges are paid. Any request for retroactive coverage in excess of six months shall be submitted to the secretary.

(b) An eligible dependent, who is not the recipient of any monthly retirement benefit from a State-administered retirement system upon the death of the retired member, will be offered the opportunity to continue participation in the State Health Benefits Program subsequent to the death of the retired member. The coverage will be no greater than the coverage that was in effect at the time of the retired member's death and will be limited to only those dependents covered at the time of the member's death. The Division of Pensions will bill the appropriate dependent at the group rate then in effect for such coverage on a quarterly calendar basis.

R.1976 d.313, eff. October 8, 1976.
See: 8 N.J.R. 443(a), 8 N.J.R. 539(a).
As amended, R.1983 d.44, eff. March 7, 1983.
See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).

The word "premium" was changed to "charge".
Amended by R.1986 d.424, effective October 20, 1986.
See: 18 N.J.R. 1452(a), 18 N.J.R. 2135(d).
(b) added.

17:9-6.7 Coverage for PFRS and SPRS accidental death benefit recipients

(a) For the purposes of this section, "eligible person" means the widow or widower and child, as defined in N.J.S.A. 43:16A-1, of a member of the Police and Firemen's Retirement System, to or for whom an accidental death benefit is payable under N.J.S.A. 43:16A-10, and the surviving spouse and child, as defined in N.J.S.A. 53:5A-3, of a member of the State Police Retirement System, to or for whom an accidental death benefit is payable under N.J.S.A. 53:5A-14.

(b) An eligible person may participate in the State Health Benefits Program regardless of whether the member's employer is a participating employer. The premiums for the coverage shall be paid by the State of New Jersey, as provided in P.L. 1989, c.271.

(c) Persons eligible to participate in the program under this section shall participate in the retiree group. If there is a widow or widower, or surviving spouse, eligible children shall participate as dependents of the widow or widower, or surviving spouse. If there is no widow or widower, or surviving spouse, eligible children shall participate as members of the program, and their eligibility to participate shall continue as long as they qualify as children under the laws governing the retirement system of the deceased member.

(d) An eligible person, as defined in (a) above, shall be eligible for coverage under the program as of February 1, 1990, or the effective date for an accidental death benefit under the retirement system of the deceased member, whichever is later. An eligible person shall receive a refund for premiums paid for health insurance coverage comparable to that provided under the program for the period from the date of eligibility for coverage under this section and the effective date of enrollment, but the refund shall not exceed the cost of the coverage under the program. An eligible person who is covered under Part B of the Federal Medicare program shall receive a refund for the amount paid for Part B. While an application for an accidental death benefit is pending, an eligible person enrolled in the program may continue coverage on a direct payment basis. If an accidental death benefit is granted, the eligible person shall receive a refund of the payments made.

New Rule, R.1990 d.481, effective October 1, 1990.
See: 22 N.J.R. 1903(b), 22 N.J.R. 3158(c).