CHAPTER 9

STATE HEALTH BENEFITS PROGRAM

Authority

N.J.S.A. 52:14-17.27.

Source and Effective Date

R.2009 d.150, effective April 6, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1.c(2), Chapter 9, State Health Benefits Program, expires on October 3, 2016. See: 48 N.J.R. 784(a).

Chapter Historical Note

All provisions of this chapter were adopted by the Commission, pursuant to authority delegated at N.J.S.A. 52:14-17.27 and became effective prior to September 1, 1969. Amendments became effective December 19, 1969 as R.1969 d.33. See: 1 N.J.R. 10(b), 2 N.J.R. 8(a).

1970 Revisions: Amendments became effective December 10, 1970 as R.1970 d.147. See: 2 N.J.R. 94(d), 3 N.J.R. 11(a).

1971 Revisions: Amendments became effective February 17, 1971 as R.1971 d.21. See: 3 N.J.R. 10(a), 3 N.J.R. 52(c). Further amendments became effective October 5, 1971 as R.1971 d.177. See: 3 N.J.R. 138(a), 3 N.J.R. 236(a).

1972 Revisions: Amendments became effective October 4, 1972 as R.1972 d.200. See: 4 N.J.R. 168(b), 4 N.J.R. 283(c).

1973 Revisions: Amendments became effective January 4, 1973 as R.1973 d.8. See: 4 N.J.R. 282(a), 5 N.J.R. 59(b). Further amendments became effective June 6, 1973 as R.1973 d.148. See: 5 N.J.R. 76(a), 5 N.J.R. 181(a). Further amendments became effective October 2, 1973 as R.1973 d.285. See: 5 N.J.R. 243(a), 5 N.J.R. 393(a).

1974 Revisions: Amendments became effective August 19, 1974 as R.1974 d.228. See: 6 N.J.R. 156(a), 6 N.J.R. 360(c).

1975 Revisions: Amendments became effective March 14, 1975 as R.1975 d.68. See: 7 N.J.R. 76(a), 7 N.J.R. 181(a). Further amendments became effective March 13, 1975 as R.1975 d.65. See: 6 N.J.R. 495(a), 7 N.J.R. 180(c). Further amendments became effective June 9, 1975 as R.1975 d.159. See: 7 N.J.R. 118(e), 7 N.J.R. 349(b).

1976 Revisions: Amendments became effective April 22, 1976 as R.1976 d.124. See: 8 N.J.R. 85(c), 8 N.J.R. 263(a). Further amendments became effective October 8, 1976 as R.1976 d.313. See: 8 N.J.R. 443(c), 8 N.J.R. 539(a).

Subchapter 8, Prescription Drug Program, was formerly codified at 17:1-10 and was adopted as R.1977 d.117, effective April 7, 1977. See: 9 N.J.R. 142(c), 9 N.J.R. 243(a).

Subchapter 9, Dental Expense Program, was formerly codified at N.J.A.C. 17:1-11 (Chapter 1) and adopted as R.1978 d.99, effective March 15, 1978. See: 10 N.J.R. 38(b), 10 N.J.R. 175(d).

1978 Revisions: Amendments became effective April 8, 1978 as R.1978 d.130. See: 9 N.J.R. 600(a), 10 N.J.R. 265(a). Further amendments became effective April 18, 1978 as R.1978 d.131. See: 10 N.J.R. 80(b), 10 N.J.R. 265(b). Further amendments became effective December 26, 1978 as R.1978 d.442. See: 10 N.J.R. 456(a), 11 N.J.R. 105(b).

1979 Revisions: Amendments became effective April 23, 1979 as R.1979 d.159. See: 11 N.J.R. 94(d), 11 N.J.R. 304(c). Further amendments became effective July 3, 1979 as R.1979 d.261. See: 11 N.J.R. 208(b), 11 N.J.R. 415(a). Further amendments became effective October 4, 1979 as R.1979 d.396. See: 11 N.J.R. 303(d), 11 N.J.R. 595(c).

1980 Revisions: Amendments became effective July 1, 1980 as R.1980 d.300. See: 12 N.J.R. 216(b), 12 N.J.R. 497(b).

1981 Revisions: Amendments became effective June 4, 1981 as R.1981 d.138. See: 13 N.J.R. 110(b), 13 N.J.R. 376(b).

1982 Revisions: Amendments became effective October 18, 1982 as R.1982 d.341. See: 14 N.J.R. 36(a), 14 N.J.R. 1165(a).

1983 Revisions: Amendments became effective March 7, 1983 as R.1983 d.44. See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b). Further amendments became effective May 2, 1983 as R.1983 d.129. See: 15 N.J.R. 81(b), 15 N.J.R. 697(b). This chapter was readopted pursuant to Executive Order 66(1978) effective May 16, 1983 as R.1983 d.177. See: 15 N.J.R. 529(a), 15 N.J.R. 930(e). Further amendments became effective August 15, 1983 as R.1983 d.332. See: 15 N.J.R. 793(a), 15 N.J.R. 1383(d).

1984 Revisions: Amendments became effective December 17, 1984 as R.1984 d.560. See: 16 N.J.R. 2422(b), 16 N.J.R. 3479(b).

1985 Revisions: Amendments became effective February 4, 1985 as R.1985 d.18. See: 16 N.J.R. 2422(a), 17 N.J.R. 320(b). Further amendments became effective April 1, 1985 as R.1985 d.165. See: 16 N.J.R. 3192(b), 17 N.J.R. 841(a). Further amendments became effective November 18, 1985 as R.1985 d.587. See: 17 N.J.R. 1399(a), 17 N.J.R. 2784(b).

1986 Revisions: Amendments became effective January 21, 1986 as R.1985 d.676. See: 17 N.J.R. 2386(a), 18 N.J.R. 2135(c). Further amendments became effective February 18, 1986 as R.1986 d.28. See: 17 N.J.R. 2868(a), 18 N.J.R. 427(b). Further amendments became effective October 20, 1986 as R.1986 d.423. See: 18 N.J.R. 1451(b), 18 N.J.R. 2135(c).

1987 Revisions: Amendments became effective December 7, 1987 as R.1987 d.497. See: 19 N.J.R. 1636(b), 19 N.J.R. 2303(b).

1988 Revisions: Pursuant to Executive Order No. 66(1978), Chapter 9 expired on June 6, 1988, and subsequently was adopted as new rules by R.1988 d.461, effective October 3, 1988. See: 20 N.J.R. 1536(a), 20 N.J.R. 2466(d). Amendments became effective October 3, 1988 d.469. See: 20 N.J.R. 1536(b), 20 N.J.R. 2466(e). Further amendments became effective October 3, 1988 as R.1988 d.471. See: 20 N.J.R. 1537(a), 20 N.J.R. 2467(a). Further amendments became effective October 17, 1988 as R.1988 d.442. See: 20 N.J.R. 741(a), 20 N.J.R. 2590(b). Further amendments became effective October 3, 1988 as R.1988 d.470. See: 20 N.J.R. 1182(a), 20 N.J.R. 2467(b).

1989 Revisions: Added new rule 1.8 effective March 6, 1989 as R.1989 d.126. See: 20 N.J.R. 2863(a), 21 N.J.R. 638(c).

Subchapter 9, Dental Expense Programs, was recodified by R.1993 d.268, effective August 2, 1993. See: 25 N.J.R. 675(b), 25 N.J.R. 3506(b).

Pursuant to Executive Order No. 66(1978), Chapter 9, State Health Benefits Program, was readopted as R.1993 d.463, effective August 23, 1993. See: 25 N.J.R. 2651(b), 25 N.J.R. 4508(b).

Pursuant to Executive Order No. 66(1978), Chapter 9, State Health Benefits Program, was readopted as R.1998 d.406, effective July 13, 1998. See: 30 N.J.R. 1919(a), 30 N.J.R. 2953(a).

Chapter 9, State Health Benefits Program, was readopted as R.2003 d.437, effective October 9, 2003. See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).

Subchapter 10, Procurement of State Health Benefits Program Contracts, was adopted as new rules by R.2004 d.106, effective March 15, 2004. See: 35 N.J.R. 5216(a), 36 N.J.R. 1359(b).

Subchapter 11, Part-Time Employees Group, was adopted as new rules by R.2004 d.191, effective May 17, 2004. See: 36 N.J.R. 22(a), 36 N.J.R. 2423(a).

Subchapter 12, Retiree Dental Expense Plan, was adopted as new rules by R.2005 d.63, effective February 22, 2005. See: 36 N.J.R. 4692(a), 37 N.J.R. 628(a).

Subchapter 13, Chapter 375 Dependents, was adopted as new rules by R.2008 d.99, effective April 21, 2008. See: 39 N.J.R. 1645(a), 40 N.J.R. 2130(a).

Chapter 9, State Health Benefits Program, was readopted as R.2009 d.150, effective April 6, 2009. See: Source and Effective Date. See, also, section annotations.

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 9, State Health Benefits Program, was scheduled to expire on April 6, 2016. See: 43 N.J.R. 1203(a).

Law Review and Journal Commentaries

State Health Benefits Program. Judith Nallin, 134 N.J.L.J. No. 3, 61 (1993).

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SUBCHAPTER 1. ADMINISTRATION

17:9-1.1 Commission meetings

(a) The State Health Benefits Commission shall meet, as necessary, at the call of the Chairperson or the Secretary provided that the required public notice has been given, pursuant to the provisions of the Open Public Meetings Act, N.J.S.A. 10:4-13.

(b) Any three members of the Commission, at least two of whom are ex-officio members, shall constitute a quorum for the purpose of conducting the business of the Commission. Each member shall be entitled to one vote and a majority of all votes of the entire Commission shall be necessary for a motion to carry.

(c) If a member is unable to attend a meeting, the member, if a member who is authorized by statute to appoint a designee, shall designate, in writing, an alternate. The person so designated shall be permitted to vote on business brought before the Commission.

(d) All Commission members and alternates shall complete all mandatory training required by either the implementing regulations of the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or the State Ethics Commission prior to hearing any appeals before the Commission.

Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
In (a), substituted "Chairperson" for "chairman"; in (c), rewrote the first sentence.
Amended by R.2004 d.21, effective January 20, 2004.
See: 35 N.J.R. 3745(a), 36 N.J.R. 440(a).
Rewrote (b); in (c), rewrote the first sentence; added (d).
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Rewrote (a); in (c), substituted "if a member who is authorized by statute to appoint a designee," for "if an ex-officio member, or the Public Employees' Committee of the AFL-CIO or the New Jersey Education Association"; and in (d), inserted "all", "either" and "or the State Ethics Commission".

17:9-1.2 Records

(a) The Secretary of the Commission shall maintain minutes of the Commission meetings in compliance with the Open Public Meetings Act (OPMA), N.J.S.A. 5:10-1 et seq. Public session minutes are public records subject to access under the Open Public Records Act (OPRA), N.J.S.A. 47:1-1 et seq and the requirements of the Federal Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. §§3210d et seq. Minutes of closed sessions pertaining to the claims of any individual shall be redacted of all personal identifying information unless the individual member waives his or her privacy interest and consents in writing to disclosure in accord with HIPAA. Minutes of executive sessions shall be subject to disclosure pursuant to the OPMA after the Commission determines the need for confidentiality no longer exists. Records of the Commission subject to public access under OPRA may be inspected during regular business hours at the office of the Division under supervision of a representative of the State Health Benefits Program or other representatives of the office. All requests for records under OPRA shall be made in writing on the required form and submitted to the Department of the Treasury Government Records Unit.

(b) To protect the personal privacy of individual participants and their families, the mailing addresses of active and retired participants and all matters related to an individual's files related to an individual's coverage and claims shall be maintained as confidential. Protected health information shall not be released to any person except as permitted under HIPAA in response to a valid HIPAA Authorization for Release of Information in a form acceptable to the Division as described in 45 CFR 164.508 or as otherwise authorized by HIPAA. The requesting party shall have the burden of demonstrating to the satisfaction of the Division that the confidential materials may be released under HIPAA.

Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Rewrote the section.

Case Notes

Board of education had sufficiently strong interest in obtaining information regarding health insurance claims paid for each employer participating in health care plan to permit it to gain access to information regarding its claims history under common-law right to inspect public records. Board of Educ. of Newark v. New Jersey Dept. of Treasury, Div. of Pensions, 145 N.J. 269, 678 A.2d 660 (1996).

Computerized claims data regarding health benefits paid under state plan constituted "public records". Board of Educ. of Newark v. New Jersey Dept. of Treasury, Div. of Pensions, 279 N.J.Super. 489, 653 A.2d 589 (A.D.1995), leave to appeal granted 142 N.J. 440, 663 A.2d 1351, affirmed 145 N.J. 269, 678 A.2d 660.

17:9-1.3 Appeals from Commission decisions

(a) Any member of the SHBP who disagrees with the decision of the claims administrator and has exhausted all appeals within the plan, may request that the matter be considered by the Commission. Requests for consideration must be directed to the Secretary of the Commission, and must contain the reason for the disagreement and all available supporting documentation. Appeals shall be considered at the regular meetings of the Commission. It shall be the responsibility of the member to provide the Commission with any medical or other information that the Commission may require in order to make a decision.

(b) Any person who disagrees with a determination made by the Division regarding their enrollment or eligibility in SHBP, may request that the matter be considered by the Commission.

(c) Notification of all Commission decisions will be made in writing to the member and 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 or her 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."

(d) Any member who disagrees with the Commission's decision and submits the written statement as set forth in (c) above within 45 calendar days shall be notified of the disposition of the appeal in one of two ways:

1. The Commission shall determine whether to grant an administrative hearing on the basis of whether the matter involves contested facts or is solely a question of law. If the appeal involves solely a question of law, the Commission shall likely deny an administrative hearing request. If the request for an administrative hearing is denied, the Commission shall issue detailed findings of fact and conclusions of law. These findings and conclusions shall become the Commission's final administrative determination that may then be appealed to the Superior Court, Appellate Division.

2. If the appeal involves disputed facts, the Commission shall approve an administrative hearing request and transmit the matter to the Office of Administrative Law. Upon completion of this hearing, the Administrative Law Judge will submit to the Commission an initial decision that the Commission may adopt, reject or modify. If the Commission rejects or modifies the initial decision, it shall issue detailed findings of fact and conclusions of law that will become the Commission's final administrative determination that may then be appealed to the Superior Court, Appellate Division.

As amended, R.1970 d.147, effective December 10, 1970.
See: 2 N.J.R. 94(d), 3 N.J.R. 11(a).
Amended by R.1996 d.551, effective December 2, 1996.
See: 28 N.J.R. 4083(b), 28 N.J.R. 5078(c).
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote (a) and (b); added new (c); recodified existing (c) and (d) as (d) and (e).
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In (a), substituted "SHBP" for "Traditional Plan", deleted "State Health Benefits" preceding the first occurrence of "Commission" and "monthly" preceding "meetings", and substituted "of the" for ", State Health Benefits" preceding the second occurrence of "Commission"; deleted former (b); recodified former (c) through (e) as (b) through (d); and in (b), deleted "of Pension and Benefits" following "Division" and "State Health Benefits" preceding "Commission".

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 Employer participation

(a) An employer joining the SHBP must adopt the resolution furnished by the Division and must agree to comply with the statutes and rules adopted by the Commission. The effective date of coverage for employers with fewer than 250 employees, COBRA participants and retired members will be the first day of the month following a period beginning 75 days after the receipt by the Commission of the completed resolution. The effective date of coverage for employers with 250 or more employees, COBRA participants and retired members will be the first day of the month following a period beginning 90 days after the receipt by the Commission of the completed resolution.

(b) The Commission may, from time to time, establish a re-entry application period for those employers who have terminated coverage. During this period, an employer who previously terminated coverage with the program may submit a resolution for re-entry.

(c) If an employer requests re-entry during any period other than that established by (b) above, 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 employer within 30 days following receipt of the resolution. The Commission may establish an administrative charge upon the employer reasonably based upon the approximate cost to the Commission of re-enrolling the employer.

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.
New Rule, R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In (a), substituted "SHBP" for "program", "rules" for "regulations", and the first occurrence of "COBRA participants" for "the Consolidated Omnibus Budget Reconciliation Act of 1985, 29 U.S.C. §§ 1161-1168 (COBRA) participants", and deleted "of Pensions and Benefits" following "Division" and "State Health Benefits" preceding "Commission" three times.

17:9-1.5 Voluntary termination of employer; notice

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

(b) When a participating employer voluntarily terminates coverage, the coverage for the employer's active and retired employees, participants under N.J.S.A. 52:14-17.29k and COBRA participants shall terminate as of the first of the month following a 60-day period beginning with the receipt of the resolution by the Commission.

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

(d) The Division shall act to notify all affected COBRA participants, participants under N.J.S.A. 52:14-17.29k, and retired members of the termination of coverage. Upon request from the employer, the Division shall forward a list of the names and addresses of terminating retirees, participants under N.J.S.A. 52:14-17.29k, and COBRA participants so that the employer may offer them an opportunity to enroll under its new group health insurance plan.

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).
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
In (a), added "and Benefits"; rewrote (b) and (d).
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In (a) and (d), deleted "of Pensions and Benefits" following "Division"; in (a), inserted "approved and" and "the governing body of the"; in (b), inserted ", participants under N.J.S.A. 52:14-17.29k", and deleted "Health Benefits" preceding "Commission"; and in (d), deleted "the Consolidated Omnibus Budget Reconciliation Act of 1985, 29 U.S.C. §§ 1161-1168 (" preceding and a closing parenthesis following the first occurrence of "COBRA", and inserted "participants, participants under N.J.S.A. 52:14-17.29k" and "participants under N.J.S.A. 52:14-17.29k,".

Case Notes

State Health Benefits Commission cannot compel participants to remain in the State Health Benefits Program by depriving them of information necessary to make an informed decision. Board of Education of Newark v. New Jersey Department of Treasury, Division of Pensions, 145 N.J. 269, 678 A.2d 660 (1996).

17:9-1.6 Default of employer; notice

(a) 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 may terminate for all members enrolled through the terminating employer.

(b) The Secretary of the Commission will notify the offices of the State Treasurer; the Attorney General; the Department of Community Affairs, Division of Local Government Service; and the Department of Education, if applicable. The Division will notify the employer and affected COBRA participants, participants under N.J.S.A. 52:14-17.29k and retired subscribers of the termination of coverage. The employer is responsible for notifying its active employees affected by this termination.

(c) Under the provisions of P.L. 2008 c. 24, the Division of Revenue of the Department of the Treasury will be responsible for collecting any outstanding debt. If necessary, the amount owed will be deducted from any amount that might otherwise be remitted by any State agency to the debtor.

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".
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Rewrote (b); and added (c).

17:9-1.7 Employer incentives for non-enrollment

(a) Except as allowed by N.J.S.A. 52:14-17.31a, 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 SHBP.

(b) Any participating local employer, other than the State is allowed to pay an employee an incentive to waive coverage if that employee is eligible for other health coverage. The incentive may be up to 50 percent of the amount saved by the employer in such a case. The employee may enroll immediately into the program if the other coverage or the waiver ends but must repay, on a pro rata basis, any amount received, which represents an advance payment for a period of time during which coverage is resumed. An employee who waives coverage under this rule is not precluded from continuing coverage into retirement.

(c) As the employer's certifying agent must sign each individual waiver application, no general resolution is required for the adoption of the waiver incentive.

Recodified from N.J.A.C. 17:9-1.8 and amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section. Former N.J.A.C. 17:9-1.7, Guidelines; local employers; purchase of contracts, repealed.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Section was "Employer incentives for non-enrollment prohibited". In (a), deleted "P.L. 1995, c. 259, P.L. 2001, c. 189 and P.L. 2003, c. 3, which are codified at" following "allowed by", and substituted "SHBP" for "State Health Benefits Program"; in (b), substituted "Any participating local employer, other than the State is allowed" for "P.L. 1995, c. 259, P.L. 2001, c. 189 and P.L. 2003, c. 3 allow a municipality, a municipal authority created by a municipality under the municipal sewerage authorities law or a county college", and inserted a comma preceding "which"; and added (c).

Case Notes

Initial Decision (2006 N.J. AGEN LEXIS 758) adopted, which found that SHBC's grant of a waiver of the requirements governing optional dental benefits coverage contained in the SHBC Guidelines for Dental Expense Contracts was not arbitrary or capricious where the guideline had never been enforced, was outdated, and the faculty association voluntarily negotiated a provision in its collective bargaining agreement contrary to the language of the guideline; it was undisputed that the regulation was about to be repealed when the SHBC granted the waiver, and was ultimately repealed. In re Faculty Ass'n of Ocean County College, OAL Dkt. No. TYP 8967-04, 2006 N.J. AGEN LEXIS 955, Final Decision (October 18, 2006), aff'd per curiam, No. A-1866-06T3, 2008 N.J. Super. Unpub. LEXIS 204 (App.Div. January 17, 2008).

17:9-1.8 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, 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.

"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, member and spouse/partner, parent and child, and family coverage, and whether prescription drug coverage is provided in the health coverage. For retirees only, the category also reflects the Medicare entitlement of the member and spouse/partner.

"Chapter 375 Dependents" means all adult children, which are defined as dependents in their parent's State health benefits coverage pursuant to P.L. 2005, c. 375 and supplemented by P.L. 2008, c. 38, which is codified at N.J.S.A. 52:14-17.29k.

"Civil union partner" means a person, who is of the same sex as the employee, with whom a legally recognized union is formed. The relationship must also satisfy the definition of a civil union as set forth in N.J.S.A. 37:1-2. Civil union certificates issued to same-sex couples from other jurisdictions are accepted under the New Jersey civil union statutes. Whenever reference is made to "marriage," "husband," "wife," "spouse," "family," "immediate family," "dependent," "next of kin," "widow," "widower," "widowed" or another word, which in a specific context denotes a marital or spousal relationship, the same shall include a civil union partner; or a domestic partnership formed outside the State of New Jersey.

"COBRA" means the Federal Consolidated Omnibus Budget Reconciliation Act of 1985, 42 U.S.C. §§1161-1168, which requires most employers sponsoring group health plans to offer employees and their eligible dependents the opportunity to temporarily extend their group health coverage in certain instances where coverage under the plan would otherwise end.

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

"Dependent" refers to any individual covered under the SHBP in addition to the subscriber (see N.J.A.C. 17:9-4.1).

"Director" means the Director of the Division of Pensions and Benefits.

"Division" means the Division of Pensions and Benefits.

"Domestic partner" (as defined by N.J.S.A. 26:8A-3) or "eligible domestic partner" means a person, who is of the same sex as the employee, who is in a committed relationship with an employee of the State of New Jersey or with an employee of a SHBP participating location that has adopted by SHBP resolution, pursuant to N.J.S.A. 52:14-17.26, the definition of dependent that includes domestic partners. The relationship must also satisfy the definition of a domestic partnership as set forth in N.J.S.A. 26:8A-4, and the domestic partners must execute and file an Affidavit of Domestic Partnership with the local registrar. The resulting Certificate of Domestic Partnership must be provided to the SHBP. Marriage certificates issued to same-sex couples do not fall under the New Jersey Domestic Partnership statutes. Pursuant to N.J.S.A. 26:8A-11 this definition does not include the

domestic partner of a participant in the SHBP who is the opposite sex of the participant. A public employer that does not participate in the SHBP may adopt this definition of domestic partner by filing a resolution for all of their retirees enrolled in the retired SHBP.

"Eligible Employer" is a public agency, the employees of which, if otherwise eligible, may join any of the retirement systems established by statute to provide retirement benefits for public employees. The term does not apply to school employers or their employees.

"Local employer" means public employers, such as counties, municipalities and authorities, including independent

State authorities not designated as "State employers" for SHBP purposes.

"Locally-administered retirement system" means an agency established under State law to provide a system of retirement benefits for public employers, which is not administered by the Division.

"Member" means any individual covered under the SHBP, regardless of whether the person is a subscriber or a dependent.

"NJ DIRECT10" means the coverage created by P.L. 2007, c. 103 as a successor plan to the "Traditional Plan" indemnity coverage.

"NJ DIRECT15" means the State's managed care plan created by P.L. 2007, c. 103 as a replacement to the "NJ PLUS" coverage.

"NJ PLUS" is the name of the State's Point of Service 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.

"Participating local employers" means public employers who elect to participate in the SHBP.

"PPO" means Preferred Provider Organization duly authorized to operate in the State which is under contract with the Commission to participate in the program.

"SHBP" means the State Health Benefits Program.

"Spouse" means a person of the opposite sex to whom one has been joined in a properly recorded legal ceremony authorized by law (as defined by N.J.S.A. 37:1-1). New Jersey recognizes legal marriages performed in other states or jurisdictions but does not recognize "common law" or any other form of marriage without a formal license (N.J.S.A. 37:1-10).

"State-administered pension fund" means a retirement system administered by the Division, including such systems as the Alternate Benefits Program.

"State-administered retirement system" means an agency established under State law to provide a system of retirement benefits for public employees.

"State biweekly employer" means an agency whose employees are paid through the State's Centralized Payroll System.

"State Employer" means the State of New Jersey and those agencies so designated by statute as "State employers" for SHBP purposes.

"State monthly employer" means an agency defined by statute as a "State employer" for SHBP purposes but independent of the State's Centralized Payroll System.

"Subscriber" means the person in whose name the coverage is listed.

"Successor plan" means a managed care plan that replaces the Traditional Plan and provides an in-network level of benefits as well as out-of-network benefits to participants with a payment of 80 percent of reasonable and customary.

New Rule, R.1996 d.298, effective June 17, 1996.
See: 28 N.J.R. 1944(a), 28 N.J.R. 3171(a).
Recodified from N.J.A.C. 17:9-1.9 and amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.
Amended by R.2005 d.187, effective June 20, 2005.
See: 37 N.J.R. 397(a), 37 N.J.R. 2212(b).
Added "Domestic partner".
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Deleted definitions "Base salary", "State biweekly sub-group" and "State monthly sub-group"; rewrote definition "Category of coverage"; and added definitions "Chapter 375 Dependents", "Civil union partner", "COBRA", "Dependent", "Director", "Division", "Eligible Employer", "Local employer", "Locally-administered retirement system", "Member", "NJ DIRECT10", "NJ DIRECT15", "PPO", "SHBP", "Spouse", "State-administered pension fund", "State-administered retirement system", "State biweekly employer", "State Employer", "State monthly employer" and "Successor plan".

17:9-1.9 Certifying officer (employer)

(a) The chief fiscal officer or other officer duly designated by a resolution of each county, municipality or public agency, and the personnel officer of the Division, Bureau or Institution of the State locations, shall serve as certifying officer for that unit.

(b) The certifying officer shall be responsible for the duties described by N.J.S.A. 52:14-17.43, including providing documentation requested by the Commission or the Division in a timely manner.

(c) The certifying officer shall be responsible for all other duties relating to matters concerning the SHBP.

(d) Upon the request of the Commission, the certifying officer shall be required to sign a statement, verifying that any information reported is accurate to the best of the officer's knowledge, and conforms with the statutes and rules governing the SHBP.

New Rule, R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).

SUBCHAPTER 2. COVERAGE

17:9-2.1 Enrollment

An eligible employee shall be eligible to enroll for coverage for the employee and the employee's eligible dependents. The employee and any dependents must enroll in the same plan.

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".
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Section was "Enrollment and charges". Rewrote the section.

17:9-2.2 Enrollment form

Within 60 days of the time an employee first becomes eligible to apply for coverage, the employee shall file a completed enrollment form indicating the employee's election to enroll or not to enroll for coverage on the employee's own behalf; and the employee's election to enroll or not to enroll any eligible dependents for coverage under one of the SHBP options. A dependent must be listed on the enrollment form to be enrolled for coverage. Appropriate legal documentation, as described in N.J.A.C. 17:9-3.3(a), verifying the dependent's relationship with the subscriber is required before enrollment is approved. If more than 60 days have passed since first eligible for enrollment, then the enrollment form shall not be processed and will be returned to the employer. The employee may then file the enrollment form during the next open enrollment period with coverage to be effective according to the schedule for that open enrollment period.

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.
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Substituted "SHBP" for "State Health Benefits Program", the third occurrence of "eligible" for "eligibility" and "according to the schedule for that open enrollment period" for "the first coverage period in January", and inserted the third sentence.

17:9-2.3 Annual open enrollment period

(a) Except as permitted under N.J.A.C. 17:9-2.4, any active employee or COBRA subscriber who did not elect to enroll for coverage for themselves or for their dependents at the time such employee or dependent first becomes eligible for coverage shall subsequently be permitted to enroll themselves and their dependents only during the annual open enrollment period, with coverage effective according to the schedule for that open enrollment period.

(b) The annual open enrollment period will be an opportunity for employees to change plan participation for themselves and their dependents. The change in the election cannot be made more frequently than once a year except as permitted under N.J.A.C. 17:9-2.4 or 2.10.

(c) The Commission may 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).
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In (a), substituted "according to the schedule for that open enrollment period" for "the first coverage period in January"; and in (c), deleted "State Health Benefits" preceding "Commission".

17:9-2.4 Coverage changes; exceptions

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

1. *Marriage, civil union and eligible domestic partnerships.* Any employee who marries or enters into an eligible domestic partnership or a civil union may enroll the employee and eligible dependents, if any, for any appropriate type of coverage by applying for coverage within the period beginning 60 days prior to the marriage, domestic partnership or civil union and ending 60 days after such marriage, domestic partnership or civil union. In the event that the spouse or partner is already enrolled as an employee, the provisions of N.J.A.C. 17:9-3.5 shall apply to such spouse's or partner's enrollment. A copy of the marriage certificate or certificate of domestic partnership or civil union must be submitted with the completed application to add the spouse/partner.

2. *Divorce; separation; termination of domestic partnership or end of civil union.* Any employee who has been enrolled or has been covered as a dependent of an enrolled employee and is subsequently divorced or ends a civil union pursuant to N.J.S.A. 2A:34 or terminates a domestic partnership pursuant to N.J.S.A. 26:8A-10 may enroll and delete from coverage or cover any eligible dependents by completing and forwarding a new enrollment form within 60 calendar days after the divorce or termination of the domestic partnership or civil union of such employee or dependent of an employee who was covered previously under the spouse's/partner's contract. A change of enrollment of this nature may also be made in the case of separation.

3. *Death of spouse, civil union partner, eligible domestic partner or dependent child.* Any employee who is

enrolled as the dependent of their spouse/partner 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.

4. *Return from military leave.* Any employee, upon return from any period of military leave without pay, may enroll the employee and any eligible dependents for any appropriate coverage by completing and forwarding an enrollment form within 60 days after the date of the employee's return to active full-time employment. In the event a dependent of an employee is discharged from military service, the employee may enroll such dependent for any appropriate coverage within the time specified above.

5. *When last dependent child reaches age 23, marries or enters into a civil union prior to that time.* Any employee who shall have enrolled one or more dependent children as dependents may enroll for any coverage at the time the last such dependent child reaches age 23, marries prior to that time, enters into a domestic partnership or civil union or becomes otherwise ineligible, by completing and forwarding a new enrollment form.

6. *An employee, spouse, eligible domestic or civil union partner or dependent ceases to be covered by other group health coverage.* If the employee, spouse, domestic or civil union partner or other dependent has other group health coverage, and then becomes ineligible for that other coverage due to qualifying events, such as termination of employment, divorce, termination of domestic or civil union partnership, death, or reduction in hours worked, the employee may enroll in any plan or for any coverage in the SHBP provided that the employee submits a new enrollment application accompanied by proof of the prior coverage, within 60 days of the qualifying event.

7. *Birth, adoption or guardianship of dependent children.* When an employee acquires qualified dependents through birth, placement for adoption, adoption, legal guardianship of children, or the assumption of direct support of children, the employee may enroll the employee and any eligible dependents for any appropriate type of coverage by completing and forwarding a new enrollment form within the period beginning 60 days prior to and ending 60 days after the birth, placement for adoption, the adoption, the guardianship or the assumption of direct support of children. Such application regarding placement for adoption, adoption, assumption of direct support of children, and guardianship shall be accompanied by legal documentation evidencing the relationship.

8. *A child resuming eligibility as a dependent child.* An employee may enroll, for any coverage, an otherwise eligible child under age 23 who, having previously been ineligible as a dependent child, resumes dependent status, resides with the parent and is financially dependent upon the parent. This applies to children whose marriage, civil union, or domestic partnership has been dissolved, as well as to children who had been considered independent by nature of employment. The employee and child must enroll in the same plan. An application for coverage shall be submitted within 60 days of the entry of a judgment of divorce or dissolution of the civil union or termination of the domestic partnership or the date the child ends employment in order to obtain coverage retroactively to the date of the re-qualifying event. Otherwise, enrollment shall be permitted only during an open enrollment.

9. *COBRA enrollment.* When an employee or dependent enrolls in the COBRA group, the employee or dependent may, within 60 days of the qualifying event, select any plan. In order for an employee or dependent to enroll in health benefit, dental or prescription coverage through COBRA, the subscriber must have been eligible for that coverage in the active group.

10. *Upon return to employment from an approved leave of absence.* Within 60 days after the return to employment from an approved leave of absence, the employee may elect to change coverage to add any eligible dependent(s) who had been removed from this group coverage while the employee was on such leave. If the employee elected not to continue his or her benefits while on leave or missed the open enrollment period, the employee may elect to enroll in any plan or coverage level as appropriate.

11. *Deference to local employer contracts.* When a local employer's contract limits coverage choices of an employee for a specified period of time after the employee's hire date, the employee may increase coverage levels provided an enrollment application is submitted within 60 days following the attainment of additional benefits provided in the contract.

(b) An employee may change the employee's enrollment and the enrollment of the employee's eligible dependents to any type of coverage under conditions other than those specified in (a) above, only during the annual enrollment period, or during a special SHBP open enrollment period.

(c) An employee who wishes to change the employee's enrollment and the enrollment of the employee's eligible dependents for any of the reasons included in (a) above, but who has failed to complete and forward the required enrollment form within the time limits therein prescribed, may effect such change of enrollment only during the annual enrollment period or during a special SHBP open enrollment period. For provisions governing coverages and charges for 10-month employees, see N.J.A.C. 17:9-5.8(c).

Amended by R.1973 d.8, effective Jan. 4, 1973.
See: 4 N.J.R. 282(a), 5 N.J.R. 59(b).
Amended by R.1989 d.335, effective July 3, 1989.
See: 21 N.J.R. 886(a), 21 N.J.R. 1836(a).
Reference to N.J.A.C. 17:9-45.11(c) added and technical changes made.
Amended by R.1993 d.249, effective June 7, 1993.
See: 25 N.J.R. 4025(c), 25 N.J.R. 2506(b).
Amended by R.1993 d.349, effective July 6, 1993.
See: 25 N.J.R. 1671(b), 25 N.J.R. 2899(a).

Amended by R.1999 d.315, effective September 20, 1999.
See: 31 N.J.R. 1468(a), 31 N.J.R. 2758(a).
Rewrote the section.
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
In (a), rewrote the first sentence of the introductory paragraph, amended the N.J.A.C. reference in 1, rewrote the second sentence in 9, rewrote 10 and deleted references to "plan" throughout; in (b), deleted "or plan"; in (c), amended the N.J.A.C. reference.
Amended by R.2005 d.187, effective June 20, 2005.
See: 37 N.J.R. 397(a), 37 N.J.R. 2212(b).
Rewrote (a).
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Inserted "or civil union" throughout; rewrote (a)1 and (a)8; in (a)2, inserted "*or end of civil union*" and "or ends a civil union pursuant to N.J.S.A. 2A:34", and deleted "or domestic" preceding "partner's"; in (a)3, inserted "*civil union partner*", substituted "their spouse/partner" for "another employee", and deleted the former last sentence; in (a)5, substituted a comma for "or" preceding "*marries*", and inserted "*or enters into a civil union*"; in (a)6, inserted "*by other group health coverage*", and substituted "SHBP" for "State Health Benefits Program"; added (a)11; and in (b) and (c), substituted "SHBP" for "State Health Benefits Program".

17:9-2.5 Employee coverage requirements

(a) For each employee who shall elect to be covered, coverage shall become effective only after all of the following conditions have been satisfied:

1. The contract or contracts are effective;

2. In the case of local coverage, the employer's participation has been approved by the Commission;

3. The employee satisfies the definition of "employee," is eligible for coverage;

4. An enrollment form has been legibly completed by the employee and the certifying officer of the employer and filed with the Health Benefits Bureau of the Division within the prescribed time limits;

5. The employee has provided a valid Social Security number for each individual to be enrolled. A Tax Identification Number will be accepted when an employee or dependent is not eligible for a Social Security number. The employee must submit a valid Social Security number within six months of the birth or adoption of a child. Employees and dependents who are foreign nationals must provide a valid Social Security number once it is obtained; and

6. The employee has provided appropriate legal documentation for each dependent to be enrolled showing the dependent's relationship with the subscriber, as set forth in N.J.A.C. 17:9-3.3(a).

Amended by R.1973 d.8, effective Jan. 4, 1973.
See: 4 N.J.R. 282(a), 5 N.J.R. 59(b).
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
In (a): deleted the gender reference in the introductory paragraph, deleted "master" preceding "contract" in 1, rewrote 4 and added 5.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In (a)4, deleted "of Pensions and Benefits" following "Division", and deleted "and" from the end; in (a)5, substituted "; and" for a period at the end; and added (a)6.

Case Notes

Leave of absence due to illness not qualifying event entitling employee to COBRA notification of continuation of benefits rights. Kilcoyne v. State Health Benefits Commission, 93 N.J.A.R.2d (TYP) 200.

17:9-2.6 Effective date for new hires; State employees and dependents

For State employees and their dependents for whom an enrollment application has been filed with the Division of Pensions and Benefits, coverage is effective on the first day of the fifth payroll period of employment for a sub-group which reports on a biweekly basis and is paid through the State Centralized Payroll System, or the first day following the completion of two months of continuous service for a sub-group which reports on a monthly basis. If employee deductions are required for coverage, deductions begin on the first day of the third payroll period of employment for biweekly sub-groups and approximately one month prior to the effective date of coverage for monthly sub-groups.

As amended, R.1973 d.8, effective Jan. 4, 1973.
See: 4 N.J.R. 282(a), 5 N.J.R. 59(b).
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 "premium" was changed to "charge".
Repeal and New Rule by R.1989 d.469, effective September 5, 1989.
See: 21 N.J.R. 1503(a), 21 N.J.R. 2807(a).
All State employees and dependents participating in the State Health Benefits Program allowed to obtain coverage within a two-month period.
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Inserted "and is paid through the State Centralized Payroll System" preceding ", or the first day following" and deleted "HMO" preceding "coverage, deductions begin".

17:9-2.7 Effective date for new hires; local employees and dependents

For local employees and their dependents for whom an enrollment application has been filed with the Division of Pensions and Benefits, coverage is effective on the first day following the completion of two months of continuous service. If employee deductions are required for coverage, deductions begin approximately one month prior to the effective date.

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 "premium" was changed to "charge".
Repeal and New Rule by R.1989 d.469, effective September 5, 1989.
See: 21 N.J.R. 1503(a), 21 N.J.R. 2807(a).
All local employees and dependents participating in the State Health Benefits Program allowed to obtain coverage within a two-month period.
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Deleted "HMO or dependent" preceding "coverage, deductions begin" and "of coverage" following "effective date".

17:9-2.8 Transfers

(a) In order to provide mobility to employees, transferring their employment from one SHBP participating employer to another, the employee may continue coverage under the program as long as they enter the service of the new employer in a period for which contributions have already been made; however, if coverage has been terminated, the employee will again have to satisfy the two-month, continuous-employment waiting period in order to obtain the coverage again. An employee hired in September under a 10-month contract is eligible for SHBP coverage during the months of July and August if they work the full 10-month contract and sufficient charges are deducted prior to the expiration of their 10-month contract to continue their coverage during the heretofore mentioned months pursuant to N.J.S.A. 52:14-17.32.

(b) For employees who will have the option of changing plans and coverage upon a transfer, as described in (a) above, a 30-day period will be available for the selection of coverage during which period their former coverage will be continued. State biweekly employees transferring from one State biweekly payroll location to another while coverage is still in force cannot make any plan changes since they are not changing employers.

Recodified from N.J.A.C. 17:9-2.9 and amended by R.2003 d. 437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.

17:9-2.9 HMO; elections

(a) Subscribers who locate in an area serviced by a participating HMO will have a 30-day period for the selection of coverage during which period their former coverage will be continued.

(b) Subscribers who are participating in an eligible HMO but who move out of the area serviced by that HMO will have a 30-day period to select one of the following options:

1. Continue participation in their current HMO Plan; or

2. Transfer participation to one of the other plans available under the SHBP.

As amended, R.1973 d.8, eff. January 4, 1973.
See: 4 N.J.R. 282(a), 5 N.J.R. 59(b).
As amended, R.1976 d.124, eff. April 22, 1976.
See: 8 N.J.R. 85(c), 8 N.J.R. 263(a).
As amended, R.1983 d.129, eff. May 2, 1983.
See: 15 N.J.R. 81(b), 15 N.J.R. 697(b).
Subsection (b) added.
Recodified from N.J.A.C. 17:9-2.10 and amended by R.2003 d. 437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Substituted "Subscribers" for "Employees" throughout; in (b), rewrote 1 and 2 and deleted 3. Former N.J.A.C. 17:9-2.9, Transfers, recodified to N.J.A.C. 17:9-2.8.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Rewrote (b)2.

17:9-2.10 Coverage for survivors—death of active employee

(a) For purposes of the continuity of coverage in the event of accidental or ordinary death where the survivors are eligible for periodic pension benefits for life, or until a dependent child is no longer eligible for such benefits, coverage may be extended until such time as the application for such death benefits is formally approved by the Board of Trustees of the retirement system paying the benefit, or by the investment carrier underwriting the individual annuity contracts. If it is not necessary for the Board of Trustees to approve the application, then the application for such benefits will be considered approved when the necessary action has been taken by the Division of Pensions and Benefits, the local retirement system, or the investment carrier.

(b) Unless the employer or the State pays for surviving spouses or surviving eligible domestic or civil union partners, the eligible survivor of the deceased employee must submit personal payments to the health benefits program in order to continue coverage. Once the survivor's annuity begins, the cost of benefits shall be deducted directly from the retirement benefit.

(c) Should coverage lapse through no fault of the survivor, who would be eligible to continue such coverage, retroactive coverage up to one year may be granted provided the payment of charges is made.

As amended, R.1973 d.8, eff. January 4, 1973.
See: 4 N.J.R. 282(a), 5 N.J.R. 59(b).
As amended, R.1979 d.159, eff. April 23, 1979.
See: 11 N.J.R. 94(d), 11 N.J.R. 304(c).
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 changed to charges.
Recodified from N.J.A.C. 17:9-2.11 and amended by R.2003 d. 437, effective November 3, 2003.
See: 34 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote (a) and (b); in (c), deleted "up to a period of three months" following "it may be granted"; Former N.J.A.C. 17:9-2.10, HMO; elections, recodified to N.J.A.C. 17:9-2.9.
Amended by R.2005 d.187, effective June 20, 2005.
See: 37 N.J.R. 397(a), 37 N.J.R. 2212(b).
In (b), inserted "or surviving eligible domestic partners" preceding ", the eligible survivor".
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In (b), inserted "or civil union"; and in (c), inserted "up to one year".

17:9-2.11 Out-of-network NJ DIRECT; eligible charges at enrollment (local employees)

(a) For purposes of local coverage, all eligible charges incurred by an eligible employee or the employee's covered dependents, from January 1 of a calendar year to the effective date of coverage for the employee's participating employer, will be considered toward satisfying the deductibles and coinsurance required under the out-of-network NJ DIRECT.

(b) For purposes of retiring members with local coverage, all eligible charges incurred by eligible retirees and their covered dependents from January 1 of a calendar year to the

effective date of coverage will be considered toward satisfying the deductibles and coinsurance required under the out-of-network NJ DIRECT coverage.

(c) The charges considered are to be eligible charges under out-of-network NJ DIRECT contract. No charges will be used to satisfy the deductibles and coinsurance for which the employee has been reimbursed by any source.

As amended, R.1984 d.560, eff. December 17, 1984.
See: 16 N.J.R. 2422(b), 16 N.J.R. 3479(b).
Deleted "being able to satisfy the normal activities test required by the contract". Inserted "not be deferred ... N.J.A.C. 17:9-2.8(b)".
Amended by R.1988 d.469, eff. October 3, 1988.
See: 20 N.J.R. 1526(b), 20 N.J.R. 2466(e).
Added "deductibles and copayments".
Recodified from N.J.A.C. 17:9-2.12 and amended by R.2003 d. 437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section. Former N.J.A.C. 17:9-2.11, Coverage for survivors, recodified to N.J.A.C. 17:9-2.10.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Section was "Traditional Plan major medical and out-of-network NJ PLUS; eligible charges at enrollment (local employees)". Substituted "DIRECT" for "PLUS" throughout; in (a), deleted "Traditional Plan major medical coverage or" preceding "out-of-network"; in (b), deleted "Traditional Plan major medical or" preceding "out-of-network"; and in (c), deleted "the Traditional Plan major medical or" preceding "out-of-network" and "and no charges will be considered that would have been paid by the basic plan, had the employee had such coverage" following "contract".

17:9-2.12 Extension of coverage charges

(a) For purposes of the payment of claims, if immediately prior to entry into the eligible classes, an employee or dependent was covered under the extension of coverage provisions, such coverage will be effective immediately but solely with respect to charges incurred in connection with the illness for which such person was covered under said extension if the following conditions are satisfied:

1. The charges would have been considered eligible charges had the extension not terminated;

2. The coverage under the extension would have not otherwise terminated.

(b) Full coverage subject to the regular rules shall begin on the payroll corresponding to the payroll on which deductions are resumed.

Recodified from N.J.A.C. 17:9-2.13 and amended by R.2003 d. 437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Former N.J.A.C. 17:9-2.12, Major Medical; eligible charges at enrollment (local employees), recodified to N.J.A.C. 17:9-2.11.

17:9-2.13 Duplication of benefits

If the State or local employer adopts separate plans for all employees or for some portion of covered employees, largely duplicating benefits provided under the SHBP medical plan, such services or benefits for the participants of such separate plans will no longer be considered eligible for reimbursement under the employee's medical plan.

Amended by R.1975 d.68, eff. March 14, 1975.
See: 7 N.J.R. 76(a), 7 N.J.R. 181(a).
As amended, R.1980 d.300, eff. July 1, 1980.
See: 12 N.J.R. 216(b), 12 N.J.R. 497(b).
Recodified from N.J.A.C. 17:9-2.15 and amended by R.2003 d. 437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
In (a), deleted gender references and references to the Major Medical Contract in the introductory paragraph. Former N.J.A.C. 17:9-2.13, Major Medical; extension of coverage charges, recodified to N.J.A.C. 17:9-2.12.

17:9-2.14 Policy provisions adoption

The Commission adopts by reference all of the policy provisions contained in the contracts between the health, prescription drug and dental plans and the Commission, as well as any subsequent amendments thereto, to the exclusion of all other possible coverages. The plans handbook supplements the master contracts and contains the specific provisions for services to be covered and those which are excluded.

R.1981 d.138, effective June 4, 1981.
See: 13 N.J.R. 110(b), 13 N.J.R. 376(b).
Recodified from N.J.A.C. 17:9-2.16 and amended by R.2003 d. 437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Substituted "health and dental plans" for "carriers, the health maintenance organizations". Former 17:9-2.14, Effective date, maternity benefits, repealed.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Deleted "State Health Benefits" preceding "Commission" twice, and inserted ", prescription drug", a comma following the second occurrence of "Commission", and the last sentence.

OAL Note: The contract provisions incorporated by reference in this rule have been filed with Administrative Publications and Filings, Office of Administrative Law, as part of the official text of this rule, but are not reproduced herein.

Case Notes

Health Benefits Commission was without statutory authority to exclude from coverage of mentally ill persons while providing coverage for mental retardation or physical disability. G.B. v. State Health Benefits Com'n, 222 N.J.Super. 83, 535 A.2d 1010 (A.D.1988).

Petitioner's daughter's condition, Agenesis of the Corpus Callosum ("ACC"), was not a "Biologically-Based Mental Illness", and thus, was not eligible for protection under N.J.S.A. 52:14-17.29(e), the Mental Health Parity Act. In re Spitale, OAL Dkt. No. TYP 6645-05, 2008 N.J. AGEN LEXIS 1326, Final Decision (October 8, 2008).

State Health Benefits Commission properly denied physical and occupational therapy for treatment of Agenesis of the Corpus Callosum (ACC) because ACC was not an illness or disease, but a congenital abnormality of brain structure where the piece of brain tissue connecting the two hemispheres was missing or not developed. The condition was biological and not a mental illness. In re Spitale, OAL Dkt. No. TYP 6645-05, 2008 N.J. AGEN LEXIS 1326, Final Decision (October 8, 2008).

Denial of fees for above average charges for medical procedures required to treat severely injured thumb upheld when determination of such fees were found proper. Rosengren v. State Health Benefits Commission, 97 N.J.A.R.2d (TYP) 9.

Claims for health benefits were ordered credited where procedures used to treat insured's diagnosed neck and facial pain were found to be commonly and customarily recognized as appropriate treatment. Urban v. State Health Benefits Commission, 96 N.J.A.R.2d (TYP) 255.

Denial of coverage for eyelid surgery as cosmetic was reasonable where there was no evidence that surgery was performed to correct vision obstruction. Weber v. State Health Benefits Commission, 96 N.J.A.R.2d (TYP) 167.

Reimbursement for installation of vehicle hand controls was properly denied where applicant failed to show medical necessity. Shanberg v. State Health Benefits Commission, 96 N.J.A.R.2d (TYP) 92.

Elderly stroke victim was not entitled to reimbursement for private duty nursing care without competent medical testimony showing medical necessity. Miller v. State Health Benefits Commission, 96 N.J.A.R.2d (TYP) 78.

Insured not entitled to reimbursement for continuing physical therapy costs. Ritscher v. State Health Benefits Commission, 96 N.J.A.R.2d (TYP) 55.

Reimbursement for surgical fees over customary charge properly denied where methodology for determining customary fees not unreasonable. Seymour v. State Health Benefits Commission, 96 N.J.A.R.2d (TYP) 33.

State health benefits provider may determine customary fee based on complexity of surgical procedure and local economic and geographic considerations. Montag v. State Health Benefits Commission, 96 N.J.A.R.2d (TYP) 23.

Private-duty nursing care and expenses denied; regular-duty nurses could have provided same services. Blumenthal v. The State Health Benefits Commission, 95 N.J.A.R.2d (TYP) 16.

Private duty nursing services following hip surgery were not a reimbursable medical necessity. Heifetz v. Benefits Commission, 93 N.J.A.R.2d (TYP) 313.

Portion of nursing costs due to preparation of insulin injections for employee's diabetes was reimbursable. Gettis v. Benefits Commission, 93 N.J.A.R.2d (TYP) 311.

Replacement of fixed bridge unit was excluded from coverage under state dental plan. Bruno v. Benefits Commission, 93 N.J.A.R.2d (TYP) 295.

Rental of passive motion machine to rehabilitate knee fracture was not reimbursable. O'Brien v. Benefits Commission, 93 N.J.A.R.2d (TYP) 263.

Private duty nursing services not medically necessary after gallbladder surgery. Naddeo v. State Health Benefits Commission, 93 N.J.A.R.2d (TYP) 198.

Medicine used for multiple sclerosis not covered by state health plan where no medical evidence supported reasonable and necessary treatment claim. Marashlian v. State Health Benefits Commission, 93 N.J.A.R.2d (TYP) 197.

Tooth implant was prosthodontic procedure or device specifically excluded from coverage under public employee's dental plan. Favale v. State Health Benefits Commission, 93 N.J.A.R.2d (TYP) 155.

Three year delay in submitting medical reimbursement claim to insurer warranted denial of claim. Zuckerman v. State Health Benefits Commission, 93 N.J.A.R.2d (TYP) 134.

Career or vocational counseling services not covered under state health benefits plan. Aronow v. State Health Benefits Commission, 93 N.J.A.R.2d (TYP) 131.

Private duty nursing at home and in hospital not medically necessary after hysterectomy. Holstein v. State Health Benefits Commission, 93 N.J.A.R.2d (TYP) 110.

Psychotherapy services provided by licensed social worker not covered under state health plan. Kahn v. State Health Benefits Commission, 93 N.J.A.R.2d (TYP) 97.

Mental health services provided by clinical social worker not covered by state health plan. Farmer v. State Health Benefits Commission, 93 N.J.A.R.2d (TYP) 67.

Calculation of reasonable and customary fee for endometrial ablation procedure upheld. Finegan v. State Health Benefits Commission, 93 N.J.A.R.2d (TYP) 65.

Support hose prescribed by physician not a covered benefit under state health benefits plan. Stanley v. State Health Benefits Commission. 93 N.J.A.R.2d (TYP) 26.

No medical coverage available for handicapped son over age 23 where employee failed to timely present medical evidence of handicap. Schultz, Jr. v. State Health Benefits Commission. 93 N.J.A.R.2d (TYP) 24.

Private duty nursing services ordered by doctor not medically necessary within meaning of state health benefits plan. Marks v. State Health Benefits Commission. 93 N.J.A.R.2d (TYP) 23.

Major medical plan exclusion for cosmetic surgery excluded coverage for bilateral otoplasty, despite approval of basic coverage plan. Palmer v. State Health Benefits Commission. 93 N.J.A.R.2d (TYP) 20.

Employee not entitled to reimbursement for psychotherapy services rendered by counselor licensed as social worker rather than psychologist or medical doctor. Goldman v. State Health Benefits Commission. 93 N.J.A.R.2d (TYP) 18.

SUBCHAPTER 3. DEPENDENTS

17:9-3.1 Dependents and children defined

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

"Children" includes stepchildren, legally adopted children, children placed in the employee's custody pending adoption, foster children and children of an eligible domestic or civil union partner who are substantially dependent upon the employee for support and maintenance. This includes children in a guardian-ward, legal relationship who are living with the employee.

"Dependents" means an employee's spouse, eligible domestic or civil union partner and the employee's unmarried children through the end of the calendar year in which they reach the age of 23 years who live with the employee in a regular parent-child relationship. "Dependents" also means unmarried children and those not in a domestic partnership or civil union, covered by their parents under the SHBP prior to the attainment of age 23, who:

1. Are incapable of self-sustaining employment by reason of mental or physical disabilities;

2. Became so incapable prior to attainment of age 23; and

3. Are substantially dependent upon such employees for support and maintenance while the insurance of the employees remain in force and the dependents remain in such conditions.

"Living with" shall be defined so as to include children in the case of divorce or termination of a domestic partnership or civil union who may not actually be living with the covered parent, but where such covered parent is required to provide for the support and maintenance of such children, and

the parent's application for dependent coverage is documented by a copy of an appropriate court order. Stepchildren and children of an eligible domestic or civil union partner must reside with the employee.

As amended, R.1969 d.33, eff. December 19, 1969.
See: 1 N.J.R. 10(b), 2 N.J.R. 8(a).
As amended, R.1972 d.200, eff. October 4, 1972.
See: 4 N.J.R. 168(b), 4 N.J.R. 283(c).
As amended, R.1976 d.313, eff. October 8, 1976.
See: 8 N.J.R. 443(c), 8 N.J.R. 539(a).
Amended by R.2001 d.27, effective January 16, 2001.
See: 32 N.J.R. 3383(a), 33 N.J.R. 291(b).
Rewrote the section.
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
In "Children" inserted "children placed in the employee's custody pending adoption" following "legally adopted children" and in "Living with", added the sentence "Stepchildren must reside with the employee.".
Amended by R.2005 d.187, effective June 20, 2005.
See: 37 N.J.R. 397(a), 37 N.J.R. 2212(b).
In "Children", substituted "pending adoption, foster children and children of an eligible domestic partner who are" for "pending adoption, foster children who are'; in "Dependents", inserted ", eligible domestic partner" following "an employee's spouse" in the introductory paragraph; in "Living with", inserted "or termination of a domestic partnership' following "divorce" and inserted "and children of an eligible domestic partner" preceding "must reside"
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Inserted "or civil union" throughout; and in the introductory paragraph of definition "Dependents", inserted "and those not in a domestic partnership or civil union", and substituted "SHBP" for "State Health Benefits Program".

Case Notes

Denial of health benefits to domestic partners of university employees did not violate anti-discrimination statute. Rutgers Council of AAUP Chapters v. Rutgers, The State University, 298 N.J.Super. 442, 689 A.2d 828 (A.D.1997).

Initial Decision (2007 N.J. AGEN LEXIS 725) adopted, which denied continuation of health care benefits for petitioner's daughter, a formerly adult disabled dependent, because, at the time the application for continued benefits was submitted, the daughter was no longer considered "disabled"; although she had a history of severe manic depression, the daughter's most recent treating physician opined that the daughter had fair control of her illness with medical management, had attended summer school, and could meet the challenge of returning to college. Cupo v. State Health Benefits Comm'n, OAL Dkt. No. TYP 4028-05, 2007 N.J. AGEN LEXIS 881, Final Decision (December 27, 2007).

Initial Decision (2005 N.J. AGEN LEXIS 673) adopted, which determined that the State Health Benefits Commission properly denied continued health benefits coverage for a public employee's son who had been injured in an automobile accident. The employee did not show by a preponderance of the credible evidence that her son was not capable of self-support due to his physical disability after turning 23 years old. The record was completely bereft of any information as to the employee's contributions to her son's support and maintenance, and it was entirely unclear whether any such contributions would constitute a substantial portion or a fraction of her son's living expenses. In re Davidson, OAL Dkt. No. TYPHB 03021-2003N, 2005 N.J. AGEN LEXIS 1063, Final Decision (December 22, 2005).

17:9-3.2 Military service

A spouse, eligible domestic or civil union partner or child enlisting or inducted into military service shall not be considered eligible for coverage during such military service.

Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Added "eligible for coverage".
Amended by R.2005 d.187, effective June 20, 2005.
See: 37 N.J.R. 397(a), 37 N.J.R. 2212(b).
Inserted ", eligible domestic partner" preceding "or child".
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Inserted "or civil union".

17:9-3.3 Certification of dependency

(a) An employee who elects to enroll an eligible dependent for any coverage shall report such dependent's relationship or status on the enrollment form and provide appropriate legal documentation for each dependent to be enrolled verifying the dependent's relationship with the subscriber. Examples of acceptable documentation include birth certificates, sworn affidavits, marriage certificates, certificates of domestic partnership or civil union, divorce and separation decrees, custody agreements and court orders. This list is not meant to be all inclusive and does not imply acceptance of any of the above without proper authentication. Such listing of the dependent shall constitute the required certification that at the time of enrollment such dependent is substantially dependent upon the employee for support and maintenance.

(b) A person who, although listed as an eligible dependent, is found to be ineligible shall be removed from coverage by the SHBP and the level of coverage of the employee or retiree shall be adjusted accordingly. Coverage for that person as a dependent shall be restored if acceptable documentation is provided to the Division, by the employee or retiree, within 60 days of written notification of the dependent's termination. If acceptable documentation is received after 60 days, the dependent shall not be restored retroactively and can only be added at the next permissible enrollment opportunity.

As amended, R.1973 d.8, eff. January 4, 1973.
See: 4 N.J.R. 282(a), 5 N.J.R. 59(b).
As amended, R.1984 d.560, eff. December 17, 1984.
See: 16 N.J.R. 2422(b), 16 N.J.R. 3479(b).
Deleted text "and such certification ... same sex and age".
Amended by R.1997 d.285, effective July 7, 1997.
See: 29 N.J.R. 1485(a), 29 N.J.R. 2844(a).
Designated existing text as (a) and added (b).
Recodified from N.J.A.C. 17:9-3.4 and amended by R.2003 d. 437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Former N.J.A.C. 17:9-3.3, Medicare, was repealed.
Amended by R.2005 d.187, effective June 20, 2005.
See: 37 N.J.R. 397(a), 37 N.J.R. 2212(b).
In (a), substituted "substantially" for "wholly" preceding dependent upon the employee"; in (b), substituted "level of coverage" for "contract level" preceding "of the employee or retiree" in the first sentence and inserted "certificates of domestic partnership," preceding "divorce and separation decrees" in the fourth sentence.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Rewrote the section.

17:9-3.4 Children with disabilities age 23 or older; determination of eligibility for continuation of coverage

(a) The determination as to the continuation of certain children with disabilities as "dependents" as defined by

N.J.A.C. 17:9-3.1 shall be made by the SHBP's medical advisors. A form requesting continuance of enrollment for an eligible dependent with disabilities must be submitted to the SHBP no later than January 31 of the year following the calendar year in which the child attained the age of 23.

(b) Children with disabilities who are age 23 or older at the time their parents obtain coverage under the SHBP who are determined by the SHBP's medical advisors to be incapable of self-sustaining employment by reason of mental or physical disabilities and who meet the requirements of "dependents" as defined by N.J.A.C. 17:9-3.1, shall not be enrolled for coverage as "dependents" as defined by N.J.A.C. 17:9-3.1 unless:

1. They were covered as dependents under a public employer's group plan immediately preceding that employer's entrance into the SHBP; or

2. They were covered as dependents under a public employer's group plan immediately preceding their parents' entrance into the SHBP under the provisions of N.J.S.A. 52:14-17.32f (qualified retirees of the Teachers' Pension and Annuity Fund), 52:14-17.32f1 (qualified retirees of the Public Employees' Retirement System who retired from boards of education or county colleges), 52:14-17.32i (qualified firefighter or law enforcement retirees from the Police and Firemen's Retirement System, Public Employees' Retirement System and Consolidated Police and Firemen's Pension Fund) or the provisions of the Intergovernmental Transfer Program (established under N.J.S.A. 11A:2-11).

As amended, R.1973 d.8, eff. January 4, 1973.
See: 4 N.J.R. 282(a), 5 N.J.R. 59(b).
New Rule, R.2001 d.27, effective January 16, 2001.
See: 32 N.J.R. 3383(a), 33 N.J.R. 291(b).
Recodified from N.J.A.C. 17:9-3.8, R.2003 d. 437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Former N.J.A.C. 17:9-3.4, Certification of, recodified to N.J.A.C. 17:9-3.3.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Substituted "SHBP" for "State Health Benefits Program" throughout; in (a) and the introductory paragraph of (b), substituted "SHBP's" for "State Health Benefits Program's" and "advisors" for "advisor"; and in (b)2, deleted "N.J.S.A." preceding "52:14-17.32f1" and "52:14-17.32i".

Case Notes

Initial Decision (2005 N.J. AGEN LEXIS 673) adopted, which determined that the State Health Benefits Commission properly denied continued health benefits coverage for a public employee's son who had been injured in an automobile accident. The employee did not show by a preponderance of the credible evidence that her son was not capable of self-support due to his physical disability after turning 23 years old. The record was completely bereft of any information as to the employee's contributions to her son's support and maintenance, and it was entirely unclear whether any such contributions would constitute a substantial portion or a fraction of her son's living expenses. In re Davidson, OAL Dkt. No. TYPHB 03021-2003N, 2005 N.J. AGEN LEXIS 1063, Final Decision (December 22, 2005).

17:9-3.5 Multiple coverage; employee and spouse

(a) In any plan offered other than an HMO, an employee who is the spouse or eligible domestic or civil union partner of another employee may elect to forego coverage as an employee and to be enrolled for coverage as a dependent, in which event no coverage shall be provided for such spouse or eligible partner as an employee while covered as a dependent. The employee of an employer other than the State, who has enrolled such spouse or eligible partner, and who is required to pay the full cost of dependent coverage, may receive a refund from the Division equivalent in amount to the employer's cost for single coverage pursuant to N.J.S.A. 52:14-17.31. When both spouses or eligible partners are covered as employees, only one may enroll their children as dependents.

(b) A similar refund shall be authorized in the case of an employee of a local participating employer who is paying the full cost of dependent coverage for a spouse or eligible partner who is an employee of the State and eligible for coverage.

(c) If spouses or eligible partners are both eligible for coverage under the program as employees:

1. Each may elect coverage as an employee and for their qualified dependents, including the spouse or eligible partner, under any plan offered other than an HMO, but only one may elect coverage for the employee and for their qualified dependents, including the spouse or eligible partner, in a participating health maintenance organization; and

2. Each may elect single coverage in any participating health maintenance organization, provided that the employee is not covered under a participating health maintenance organization as a dependent of a spouse or eligible partner.

Amended by R.1973 d.8, effective January 4, 1973.
See: 4 N.J.R. 282(a), 5 N.J.R. 59(b).
Recodified from N.J.A.C. 17:9-3.9 and amended by R.2003 d. 437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section. Former N.J.A.C. 17:9-3.5, Eligible dependents, was repealed.
Amended by R.2005 d.187, effective June 20, 2005.
See: 37 N.J.R. 397(a), 37 N.J.R. 2212(b).
In the last sentence of (a) and in the introductory paragraph of (c), substituted "spouses or eligible domestic partners" for "husband and wife"; inserted "or eligible domestic partner" following "spouse" throughout.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In (a), substituted "In any plan offered other than an HMO" for "For Traditional Plan coverage", inserted "or civil union", deleted "domestic" preceding the second and third occurrences of "partner", "of Pension and Benefits" following "Division" and "domestic" preceding "partners"; in (b), (c)1 and (c)2, deleted "domestic" preceding "partner" throughout; in the introductory paragraph of (c), deleted "domestic" preceding "partners"; in (c)1, substituted "any plan offered other than an HMO" for "the Traditional Plan or NJ PLUS"; and in (c)2, inserted "a" preceding "participating".

SUBCHAPTER 4. EMPLOYEES

17:9-4.1 State employee defined

(a) For purposes of State coverage, "employee" shall mean an appointive or elective officer or full-time employee of the State including employees of:

1. Rutgers, the State University of New Jersey;

2. Palisades Interstate Park Commission;

3. University of Medicine and Dentistry of New Jersey;

4. New Jersey Institute of Technology;

5. The State colleges and universities as designated by their boards of trustees; and

6. Agencies or special projects which are supported from or whose employees are paid from sources of revenue, other than general funds, which other funds will bear the cost of benefits under this Act.

Amended by R.1973 d.8, effective January 4, 1973.
See: 4 N.J.R. 282(a), 5 N.J.R. 59(b).
Amended by R.1983 d.330, effective August 15, 1983.
See: 15 N.J.R. 792(b), 15 N.J.R. 1383(c).
Change name to University of Medicine and Dentistry of New Jersey.
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
In (a), deleted 2, recodified former 3 and 4 as 2 and 3, added new 4 and 5, recodified former 5 as 6.

17:9-4.2 State; full-time defined

(a) For purposes of State coverage, "full-time" shall mean:

1. The normal full-time weekly schedule for the particular class title, and in any case not less than 35 hours per week;

2. Employment for 12 months, except in the case of those employees engaged in activities where the regular and normal work schedule is ten months;

3. Sabbaticals where the compensation paid is 50 percent or more of the salary granted just prior to the leave and the period of eligibility terminates with the end of the fiscal year;

4. Public defenders who are paid on the basis of an average 30-hour work week schedule, notwithstanding N.J.A.C. 17:9-4.4;

5. Employees of the University of Medicine and Dentistry of New Jersey who are paid for a minimum of 20 hours per week, notwithstanding N.J.A.C. 17:9-4.4; and

6. Teaching assistants and graduate assistants at Rutgers, the State University, who are paid for a minimum of 15 hours, notwithstanding N.J.A.C. 17:9-4.4.

(b) Where the otherwise eligible employee elects a voluntary furlough, as authorized by P.L. 1993, c.297, coverage shall continue with the employer paying the costs as if the member were an active employee, provided that the employee remits in advance to the employer the amount required, if any, as the employee's contribution for coverage.

Amended by R.1973 d.8, effective January 4, 1973.
See: 4 N.J.R. 282(a), 5 N.J.R. 59(b).
Amended by R.1975 d.68, effective March 14, 1975.
See: 7 N.J.R. 76(a), 7 N.J.R. 181(a).
Amended by R.1983 d.330, effective August 15, 1983.
See: 15 N.J.R. 792(b), 15 N.J.R. 1383(c).
Change name to University of Medicine and Dentistry of New Jersey.
Amended by R.1988 d.442, effective October 17, 1988.
See: 20 N.J.R. 741(a), 20 N.J.R. 2590(b).
Added (a)7.
Amended by R.1990 d.480, effective October 1, 1990.
See: 22 N.J.R. 1903(a), 22 N.J.R. 3158(b).
Deleted text from (a)7 and inserted new.
Amended by R.1993 d.57, effective April 5, 1993.
See: 24 N.J.R. 2345(a), 25 N.J.R. 1518(a).
Revised (a)7.
Amended by R.1995 d.3, effective January 3, 1995.
See: 26 N.J.R. 2202(a), 27 N.J.R. 128(a).
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
In (a), added N.J.A.C. reference in 4; and deleted 7.

Case Notes

Under statute requiring the minimum level of coverage for health benefits for local government employees to be substantially equivalent to the level available to State employees, Health Benefits Commission held able to increase health benefits available to participating local government employees when benefits available to State employees were increased as a result of negotiated agreement between the State and its employees. New Jersey School Boards Ass'n v. Ewing Tp. Bd. of Educ., Mercer Cty., 183 N.J.Super. 215, 443 A.2d 761 (App.Div.1982).

17:9-4.3 Ineligible employees defined

(a) For purposes of State and local coverage, "employee" shall not mean:

1. Any person with less than two months of continuous service;

2. Any person whose compensation is limited to reimbursement of necessary expenses actually incurred in the discharge of his official duties;

3. Any person compensated on a fee basis (see N.J.A.C. 17:9-4.5);

4. Any person who is employed on short-term, seasonal, intermittent or emergency basis such as a person whose compensation is in the nature of a "retainer", or is for occasional services or whose service is for brief periods at intervals, such as substitute teachers;

5. Any person whose compensation is paid or payable by voucher;

6. Any person whose services are not full-time;

7. Any person granted a sabbatical where the compensation paid is less than 50 percent of the salary granted just prior to the leave;

8. Any person who is an aide or patient employee in a State, county or municipal institution;

9. Any person suspended from work without pay for more than one full coverage period as the result of disciplinary action for the period of suspension.

Amended by R.1971 d.21, effective February 17, 1971.
See: 3 N.J.R. 10(a), 3 N.J.R. 52(c).
Amended by R.1973 d.285, effective October 2, 1973.
See: 5 N.J.R. 243(a), 5 N.J.R. 393(a).
Amended by R.1978 d.441, effective December 26, 1978.
See: 10 N.J.R. 517(b), 11 N.J.R. 105(a).
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
In (a), rewrote 9.

Case Notes

Continuation of health benefits to school psychologist after reduction in work week to 18 hours denied; board of education's policy limiting health benefits to full time employees, that is, to those working more than 20 hours per week, held reasonable in view of State health program rules. Janus v. Maywood Bd. of Educ., Bergen Cty., 4 N.J.A.R. 105 (1982).

17:9-4.4 State; ineligible employees defined

(a) For purposes of State coverage, "employee" shall not mean any person who is paid:

1. An hourly rate (payroll compensation code 7) except that a full-time employee with a Civil Service title assigned an hourly salary range is eligible;

2. A daily rate (payroll compensation code 8);

3. A rate per meeting, session (payroll compensation code 8);

4. A salary based on a percentage of full-time (payroll compensation code 6);

5. Any person who is not on a State, college or university payroll or payroll of agencies identified in N.J.A.C. 17:9-4.1;

6. Any otherwise eligible employee for whom the State, directly or indirectly, provides benefits under any other plan, which benefits have a value equal to or in excess of the benefits payable under the State Health Benefits Act.

Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
In (a), deleted former 5, recodified former 6 as 5, deleted former 7, recodified former 8 as 6.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Rewrote (a)5.

17:9-4.5 Local; employee defined

(a) For purposes of local coverage, "employee" shall mean an appointive or elected officer or full-time employee of the local employer, including an employee who is compensated on a fee basis as a convenient method of payment of wages or salary, but who is not a self-employed, independent contractor compensated in a like manner.

(b) To qualify for coverage as an appointive officer, an employee must be:

1. Appointed to an office specifically established by law, ordinance, resolution or such other official action required by law for establishment of a public office by an appointing authority. A person appointed under a general authorization, such as, "to appoint officers" or "to appoint such other officers," or similar language, is not eligible to participate as an appointive officer and must qualify for participation as a full-time employee; and

2. The employee must be invested with some portion of political power partaking in any degree in the administration of civil government, and the duties of such employment must emanate from the sovereign authority. The employee's duties must be integral to local government, and the employee must have some authority to make decisions on behalf of the civil government.

Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Designated existing text as (a); added (b).

Case Notes

Under statute requiring the minimum level of coverage for health benefits for local government employees to be substantially equivalent to the level available to State employees, Health Benefits Commission held able to increase health benefits available to participating local government employees when benefits available to State employees were increased as a result of negotiated agreement between the State and its employees. New Jersey School Boards Ass'n v. Ewing Tp. Bd. of Educ., Mercer Cty., 183 N.J.Super. 215, 443 A.2d 761 (App.Div.1982).

17:9-4.6 Local; full time defined

(a) For purposes of local coverage, "full-time" shall mean:

1. Employment of any eligible employees who appear on a regular payroll and who receive a salary or wages for an average of the number of hours per week as prescribed by the governing body of the participating employer. Each participating employer shall, by resolution, determine the number of hours worked which shall be considered to be "full-time." In no case shall the number of hours for "full-time" be less than 20.

2. The employer, at its option, may grandfather all employees who were eligible for coverage under the location's previous definition of "full-time."

3. Sabbaticals where the compensation paid is 50 percent or more of the salary granted just prior to the leave and the period of eligibility terminates with the end of the fiscal year.

(b) Where an otherwise eligible employee elects a voluntary furlough, as authorized by P.L. 1993, c. 297 for State employees and extended to local employers pursuant to N.J.A.C. 4A:6-1.23(b), coverage shall continue with the employer paying the costs as if the member were an active employee, provided that the employee remits in advance to the employer the amount required, if any, as the employee's contribution for coverage.

Amended by R.1983 d.43, effective March 7, 1983.
See: 14 N.J.R. 1296(a), 15 N.J.R. 343(c).
Minimum hours per week changed to an average of hours per week.
Amended by R.1995 d.644, effective December 18, 1995.
See: 27 N.J.R. 2680(a), 27 N.J.R. 5040(a).
Amended by R.1999 d.395, effective November 15, 1999.
See: 31 N.J.R. 2300(a), 31 N.J.R. 3742(a).
Added (b).
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
In (a), added new 2 and recodified former 2 as 3.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In (b), substituted "c. 297" for "c.297", substituted "pursuant to" for "through the Department of Personnel's rulemaking authority (see", and deleted the closing parenthesis following "4A:6-1.23(b)".

Case Notes

Permanent school based substitute teachers; sick leave and benefits. East Orange Education Association v. East Orange Board of Education, 94 N.J.A.R.2d (EDU) 366.

Continuation of health benefits to school psychologist after reduction in work week to 18 hours denied; board of education's policy limiting health benefits to full time employees, that is, to those working more than 20 hours per week, held reasonable in view of State health program rules. Janus v. Maywood Bd. of Educ., Bergen Cty., 4 N.J.A.R. 105 (1982).

17:9-4.7 Multiple positions

For purposes of State and local coverage, "full-time" shall mean employment of an employee who holds multiple public positions with the same employer which in the aggregate would meet the eligibility requirements for coverage as a full time employee. If an employee holds multiple public positions with multiple employers, the employee must meet the eligibility requirements for coverage with each employer to get coverage from that employer.

Amended by R.1973 d.8, effective January 4, 1973.
See: 4 N.J.R. 282(a), 5 N.J.R. 59(b).
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.

SUBCHAPTER 5. CHARGES

17:9-5.1 Separate experience; State and local

The experience of local employers may be considered separately from that of the State. The Commission may particularize subgroups for the purposes of determining rates.

As amended, R.1973 d.8, eff. January 4, 1973.
See: 4 N.J.R. 282(a), 5 N.J.R. 59(b).
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Substituted "may" for "should" in the first sentence and added a second sentence.

Case Notes

Under statute requiring the minimum level of coverage for health benefits for local government employees to be substantially equivalent to the level available to State employees, Health Benefits Commission held able to increase health benefits available to participating local government employees when benefits available to State employees were increased as a result of negotiated agreement between the State and its employees. New Jersey School Boards Ass'n v. Ewing Tp. Bd. of Educ., Mercer Cty., 183 N.J.Super. 215, 443 A.2d 761 (App.Div.1982).

Petitioner not entitled to refund of premiums paid during period of time he was ineligible for SHBP coverage. Izzo v. State Health Benefits Commission, 94 N.J.A.R.2d (TYP) 219.

17:9-5.2 Charges; interest charges

(a) By adoption of the appropriate resolution, the employer may request a premium delay of 30 or 60 days after the customary due date for such charges. If the employer terminates participation, any amounts outstanding must be paid with the final billing.

(b) For the purpose of local coverage, the employer must remit to the Division charges covering a one-month period by the due date printed on the bill.

(c) If the transmittal report and full payment of health benefits charges are not received within 15 days of the due date, as cited on the monthly transmittal mailed from the Division, interest at the rate of one percent per annum above the average annualized daily rate of return on the State Cash Management Fund as published by the Division of Investment for the most recent fiscal year shall be applied to the total transmittal of health benefits charges from the 16th day until the payment is received. The interest penalty will also be applied if payment is received by the Health Benefits Bureau without the transmittal report for proper distribution.

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 "premiums" was changed to "charges".
Amended by R.1986 d.28, effective February 18, 1986.
See: 17 N.J.R. 2868(a), 18 N.J.R. 427(b).
(b) added.
Recodified from N.J.A.C. 17:9-5.3 and amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Added a new (a), recodified former (a) and (b) as (b) and (c) with amend to new (b). Former N.J.A.C. 17:9-5.2, Waiting period, was repealed.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In (b) and (c), deleted "of Pensions and Benefits" following "Division"; and in (b), deleted "in the Traditional Plan," following "local coverage,".

17:9-5.3 Local employer payment of charges

(a) The obligations of a participating employer other than the State to pay the premium or periodic charges for health benefits coverage may be determined by means of a binding collective negotiations agreement.

(b) With respect to employees for whom there is no majority representative for collective negotiations purposes, the employer may, in its sole discretion, modify the respective payment obligations set forth in law for the employer and such employees for the coverage of the employee and enrolled dependents in a manner consistent with the terms of any collective negotiations agreement binding on the employer. In the absence of any collective negotiations agreement, the employer may modify the payment obligations as it deems appropriate.

(c) Should the payment obligations of employees change as a result of the implementation of a collection negotiations agreement binding on the employer, or upon the extension of such an agreement to employees for whom there is no majority representative for collective negotiations purposes, the employer must notify the Division of Pensions and Benefits by submission of the appropriate resolution.

(d) The employer shall give all affected employees an opportunity for completing and forwarding a new enrollment form within 60 days following the change in the employee's cost.

(e) Any affected employee who fails to complete and forward the required form within the time limits, which have been prescribed, may effect such change of enrollment only during the annual enrollment period.

(f) The Division assumes no responsibility for maintaining coverage in accordance with the employer's legal obligations.

(g) No retroactive enrollment, coverage changes or terminations will be processed to meet the contract provisions.

As amended, R.1973 d.8, eff. January 4, 1973.
See: 4 N.J.R. 282(a), 5 N.J.R. 59(b).
As amended, R.1974 d.229, eff. August 19, 1974.
See: 6 N.J.R. 123(b), 6 N.J.R. 360(d).
Recodified from N.J.A.C. 17:9-5.4 and amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote (b) and (c) and deleted the gender reference in (d). Former N.J.A.C. 17:9-5.3, Advance changes; interest charges, recodified to N.J.A.C. 17:9-5.2.
Amended by R.2008 d.159, effective June 16, 2008.
See: 39 N.J.R. 5069(a), 40 N.J.R. 3747(b).
Section was "Local employer payment of dependent charges". Rewrote (a) through (c); in (d), inserted "affected", deleted a comma following "completing" and substituted "change in the employee's cost" for "employer's assumption of the dependent premium charges"; in (e), inserted "affected" and inserted a comma following "limits"; and added (f) and (g).
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In (b), inserted the last sentence.

17:9-5.4 Local employer resolution; P.L. 1974, c. 88; P.L. 1979, c. 54; P.L. 1999, c. 48

(a) A local employer will satisfy the requirements of P.L. 1974, c. 88, by adopting a resolution designed to:

1. Apply to all eligible present and future pensioners of the employer and their dependents;

2. Continue as long as the employer participates in the program;

3. Provide for local employer reimbursement of Federal Medicare charges for eligible pensioners and/or their spouses and partners, as well as the payment of health insurance charges required by the program, on a basis comparable to the reimbursement made by the State to its eligible pensioners and their spouses and partners in accordance with the provisions of P.L. 1972, c. 75 (see N.J.A.C. 17:9-5.5);

4. Require the local employer to pay the full cost of NJ DIRECT or HMO coverage;

5. Provide for an effective date not earlier than the first day of the month at least 90 days following receipt of the local employer's resolution on forms approved by the Division.

(b) A local employer may also adopt an additional resolution designed to apply to all eligible pensioners and their dependents who retired on or after July 1, 1964, in accordance with the provisions of P.L. 1979, c. 54. Such resolution shall meet the prescriptions of (a) above.

(c) Under the provisions of P.L. 1981, c. 436, as amended, an educational or local employer may also adopt an additional resolution designed to apply the provision of P.L. 1974, c. 88 to surviving spouses and eligible partners of qualified retirees.

(d) Under the provisions of P.L. 1981, c. 436, as amended, an educational or local employer may also adopt an additional resolution designed to apply the provision of P.L. 1974, c. 88 to those former employees who retired since the employer adopted the provisions of the SHBP but who did not continue coverage because of the cost to the member.

(e) Under the provisions of P.L. 1999, c. 48 (N.J.S.A. 52:14-17.38), a participating local employer, excluding employers deemed to be covered by N.J.S.A. 52:14-17.28b or employees of school boards covered by N.J.S.A. 52:14-17.32f, 17.32f1 and 17.32f2 may by resolution adopt any of the age and service requirements found in N.J.S.A. 52:14-17.38 in determining eligibility to qualify for employer-paid post-retirement medical benefits. A participating local employer may also negotiate payment obligations with their employees for post-retirement medical benefits. The payment obligations of the participating local employer shall be the payment obligations applicable to the employee on the date the employee retires on a disability pension or the date the employee meets the retirement system service credit and employment service requirements for the employer payment of coverage as established by the resolution adopting the provisions of P.L. 1999, c. 48.

As amended, R.1971 d.177, eff. October 5, 1971.
See: 3 N.J.R. 138(a), 3 N.J.R. 236(a).
As amended, R.1973 d.285, eff. October 2, 1973.
See: 5 N.J.R. 243(a), 5 N.J.R. 393(a).
As amended, R.1975 d.65, eff. March 13, 1975.
See: 6 N.J.R. 495(a), 7 N.J.R. 180(c).
As amended, R.1979 d.396, eff. October 4, 1979.
See: 11 N.J.R. 303(d), 11 N.J.R. 595(c).
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".
Recodified from N.J.A.C. 17:9-5.5 and amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section. Former N.J.A.C. 17:9-5.4, "Local employer payment of dependent charges", recodified to N.J.A.C. 17:9-5.3.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Section was "Local employer resolution; P.L. 1974, c.88; P.L. 1979, c.54; P.L. 1999, c.48". In the introductory paragraph of (a), substituted "c. 88" for "c.88"; in (a)3, inserted "and partners" twice, and substituted "c. 75" for "c.75"; in (a)4, substituted "NJ DIRECT" for "Traditional, NJ PLUS,"; in (b), substituted "c. 54" for "c.54" and "(a) above" for "subsection (a) of this section"; in (c) and (d), substituted "c. 436" for "c.436" and "P.L. 1974, c." for "Chapter"; in (c), inserted "and eligible partners"; in (d), substituted "SHBP" for "State Health Benefits Program"; and in (e), substituted "c. 48" for "c.48" twice, and inserted "retirement system" and "employment".

Case Notes

Statute calls for uniformity in coverage to all eligible employees with respect to contracts made on prospective basis. Weiner v. County of Essex, 262 N.J.Super. 270, 620 A.2d 1071 (L.1992).

County, which was successor to county welfare board, was collaterally estopped from asserting defenses that it did not specifically assume obligation to pay postretirement medical benefits. Weiner v. County of Essex, 262 N.J.Super. 270, 620 A.2d 1071 (L.1992).

Requirement of paragraph (a)1 held valid as reasonable and necessary for the administration of the Health Benefits Program Act; denial of implementation of negotiated health benefits plan by Commission upheld due to discrimination between eligible employees. New Jersey Policemen's Benevolent Ass'n Local # 42 v. New Jersey State Health Benefits Commission, 153 N.J.Super. 152, 379 A.2d 285 (App.Div.1977).

17:9-5.5 Medicare refunds

(a) Where the State, directly or indirectly, reimburses the retiree for the Medicare Part B charges:

1. The amount of the reimbursements made for Medicare Part B shall be determined by law or, through a collective bargaining agreement or contract, but in no case shall it exceed the standard monthly cost of Medicare Part B.

2. As Medicare Part B premium reimbursements are dependent upon sufficient annual appropriations from the legislature, eligible reimbursements regarding Medicare Part B premiums will include only those premiums that have been paid for the period up to 12 months immediately preceding receipt of proof of Medicare and not those paid prior to the 12 months immediately preceding receipt of proof of full Medicare entitlement.

3. Wherever possible, the reimbursement will be added directly to the retirement allowance.

4. Where the reimbursement cannot be added to the retirement allowance, a separate check for the reimbursement will be mailed to the retiree. All reimbursements made for Medicare Part B shall be made payable to the retiree.

(b) Where authorized by law, a participating local employer paying for the cost of coverage for enrollment in an SHBP Plan for a retiree may reimburse the retiree for all or part of the cost of Part B of the Federal Medicare program for the retiree and enrolled spouse or eligible domestic or civil union partner, as appropriate. The participating local employer is responsible for the payment of such reimbursements.

(c) All reimbursements made pursuant to (b) above shall be made payable to the retiree constituting the most timely payment for Medicare Part B coverage. The amount of the reimbursement shall be determined by law or, through a collective bargaining agreement or contract, but in no case shall it exceed the standard monthly cost of Medicare Part B. The reimbursement shall be made as frequently as determined by the participating local employer, but not less frequently than annually. As with the State, local employers are limited by budget allocations; therefore, retroactive refunds are limited to one year.

(d) In no event shall duplicate reimbursements be made to any retiree for the retiree or the retiree's spouse or eligible domestic or civil union partner. If the spouse or eligible partner of a retiree receives reimbursement for Medicare Part B by the State in their retirement allowances, then the spouse or partner shall only be eligible for the Medicare Part B reimbursement based upon their employment and not the retiree's employment. Spouses or partners reimbursed directly by their employer and not through the State must submit proof that they have waived that other Medicare Part B reimbursement in order to be reimbursed as a spouse or partner of the retiree. In addition, the retiree is not eligible to receive reimbursement for the difference between the amounts reimbursed to a spouse or partner from other Medicare Part B reimbursement and the amounts reimbursed to the retiree under the SHBP.

(e) Any overpayment of Medicare Part B premiums by the State shall be deducted from the retiree's retirement allowance or from any retirement or death benefit due the retiree's beneficiary or estate.

New Rule, R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Former N.J.A.C. 17:9-5.5, "Local employer resolution; Chapter 88, P.L. 1974; Chapter 54, P.L. 1979", recodified to N.J.A.C. 17:9-5.4.
Amended by R.2005 d.187, effective June 20, 2005.
See: 37 N.J.R. 397(a), 37 N.J.R. 2212(b).
Rewrote the section.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In (b) and (d), inserted "or civil union"; in (b), substituted "an" for "a" preceding "SHBP"; in (c), deleted "part" preceding "(b)"; and in (d), deleted "domestic" preceding "partner" and "partners" throughout.

17:9-5.6 Refunds rejected

Any request for refund not specified in N.J.A.C. 17:9-3.5 and 5.5 shall be denied. For example, a member and spouse or eligible partner may be employed in the same or in different locations, each location participating in the SHBP and both having family coverage, or both having member and spouse/partner coverage; in spite of the apparent duplication of coverage, neither of the covered employees would be eligible for a refund. Or, the spouse or eligible partner carries only single employee coverage under the State program while the member is covered by a plan in private industry where the employer pays for employee and dependent coverage; no refund would be payable since both would have to have been in public employment covered by the SHBP. Or, if one spouse or eligible partner applies for Medicare reimbursement for the member and spouse or eligible partner, the other shall not receive duplicate reimbursement.

Amended by R.1973 d.8, eff. January 4, 1973.
See: 4 N.J.R. 282(a), 5 N.J.R. 59(b).
Amended by R.1976 d.313, eff. October 8, 1976.
See: 8 N.J.R. 443(c), 8 N.J.R. 539(a).
Recodified from N.J.A.C. 17:9-5.9 and amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Amended N.J.A.C. references and neutralized gender references.
Former N.J.A.C. 17:9-5.6, (Reserved), was deleted.
Amended by R.2005 d.187, effective June 20, 2005.
See: 37 N.J.R. 397(a), 37 N.J.R. 2212(b).
Substituted "SHBP" for "State program" in the third sentence; inserted "or eligible domestic partner" following "spouse" throughout.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).

Deleted "domestic" preceding the first, third, fourth and fifth occurrences of "partner" and "or domestic" preceding the second occurrence of "partner", and substituted "SHBP" for "State Health Benefits Program".

Case Notes

County was not entitled to a refund of health care benefit premiums erroneously paid on behalf of terminated employees or employees who were eligible for lower premiums. Essex County v. State Health Benefits Commission, 93 N.J.A.R.2d (TYP) 317.

17:9-5.7 Retroactive charges; payment due

Retroactive charges covering the entire period of retroactivity will be calculated on the basis of the charge in effect on the subscriber's effective date of coverage.

Amended by R.1975 d.159, eff. June 9, 1975.
See: 7 N.J.R. 118(e), 7 N.J.R. 349(b).
As amended, R.1983 d.44, eff. March 7, 1983.
See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).
"premiums" was changed to "charges".
Recodified from N.J.A.C. 17:9-5.10 and amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Substituted "subscriber's effective date of coverage" for "date the employee is actually enrolled". Former N.J.A.C. 17:9-5.7, State and local; multiple coverage refunds, was repealed.

17:9-5.8 Charges and coverage; 10-month employees

(a) Employees hired as of September 1 under a 10-month contract shall have any premiums for which they may be responsible deducted from the wages they received in September to establish their coverage as of the beginning date of their employment. In order to continue a 10-month employee's coverage during the months of July and August, sufficient charges will be deducted prior to the expiration of their 10-month contract to continue their coverage during the heretofore mentioned months.

(b) Regarding 10-month contract State employees paid on a biweekly basis through the State's Centralized Payroll System, the effective date of coverage for September enrollments will be the period which is the one nearest September 1.

(c) A 10-month employee whose employment resumes in September may enroll eligible dependents within 60 days of the qualifying event. Should any part of the 60-day period occur during July and August, that period will be extended day for day up to 60 days after the employee resumes work in September.

R.1978 d.131, eff. April 18, 1978.
See: 10 N.J.R. 80(b), 10 N.J.R. 265(b).
As amended, R.1982 d.341, eff. October 18, 1982.
See: 14 N.J.R. 36(a), 14 N.J.R. 1165(a).
Clarified coverage of biweekly cases of 10-month employees.
As amended, R.1983 d.330, eff. August 15, 1983.
See: 15 N.J.R. 792(b), 15 N.J.R. 1383(c).
The word "premiums" replaced by "charges".
Amended by R.1989 d.335, effective July 3, 1989.
See: 21 N.J.R. 886(a), 21 N.J.R. 1836(a).
Provisions governing coverages and charges for 10-month employees added at (c).
Recodified from N.J.A.C. 17:9-5.11 amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
In (a), substituted "any premiums for which they may be responsible" for "charges" and deleted "provided their employment resumes in September" following "mentioned months"; in (b), inserted "through the State's Centralized Payroll System" following "biweekly basis". Former N.J.A.C. 17:9-5.8, Medicare refunds, was repealed.

17:9-5.9 Health Contribution for active employee State Health Benefit Coverage

Pursuant to P.L. 2007, c. 103, (N.J.S.A. 52:14-17.28b), a deduction in the amount of 1.5 percent of base salary shall be made for each covered State employee, as negotiated. For purposes of this section, base salary means an employee's annual base salary, not including any bonuses, overtime or longevity payment.

New Rule, R.1996 d.298, effective June 17, 1996.
See: 28 N.J.R. 1944(a), 28 N.J.R. 3171(a).
Amended by R.2000 d.298, effective July 17, 2000.
See: 32 N.J.R. 1322(a), 32 N.J.R. 2601(b).
In (a), inserted a reference to HMO coverage; in (b), inserted "and ending June 30, 1997 for monthly sub-groups and the last day of the payroll period closest to July 1, 1997 for bi-weekly sub-groups" in the first sentence of 1, and inserted "and ending June 30, 2000 for monthly and bi-weekly sub-groups" in the first sentence of 2; in (c), added "and ending June 30, 2000 for monthly and bi-weekly sub-groups" at the end; and added (e).
Recodified from N.J.A.C. 17:9-5.12, and amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Former N.J.A.C. 17:9-5.9, Refunds rejected, was recodified to N.J.A.C. 17:9-5.6.
Repeal and New Rule, R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Section was "Premium-sharing for active employee State Health Benefits Coverage".

SUBCHAPTER 6. RETIREMENT

17:9-6.1 Retired employee defined

(a) "Retired employee" means a person who is eligible for coverage under the SHBP's retiree group. This "retired employee" status, once established, shall continue in effect even though the employer is subsequently disbanded and no successor agency is created upon the dissolution of such employer.

(b) The definition of "retired employee" also includes the following classes of retired employees who are eligible for coverage:

1. Retired employees of the State of New Jersey and of employers defined as State agencies in N.J.S.A. 52:14-17.26, who were eligible for coverage as active employees immediately prior to retirement and who continued coverage at retirement;

2. Retired employees of educational and local employers participating in this Program who were eligible for

coverage as active employees immediately prior to retirement and who continued coverage at retirement;

3. Retired employees of educational and county college employers, regardless of the employer's participation in the SHBP who:

i. Were full-time employees as defined by N.J.A.C. 17:9-4.6;

ii. Were eligible for group health plan coverage prior to leaving employment; and

iii. Retired on disability retirements or on benefits based upon 25 or more years of service credit in the Teachers' Pension and Annuity Fund, the Public Employee's Retirement System, the Alternate Benefits Program or in a locally administered pension fund established by N.J.S.A. 18A:66-94 et seq. under the provisions of P.L. 1987, c. 384, P.L. 1992, c. 126 or P.L. 1995, c. 357 (N.J.S.A. 52:14-17.32f, 52:14-17.32f1 and 52:14-17.32f2);

4. Qualified retired employees of boards of education who receive a retirement benefit from a State or locally administered retirement system and who:

i. Have continued their employer's plan;

ii. Become entitled to and enroll in Parts A and B of the Federal Medicare Program; and

iii. Within 60 days of enrollment in Parts A and B of the Federal Medicare Program, elect to join the SHBP under the provisions of P.L. 1993, c. 8 (N.J.S.A. 52:14-17.32h). A retired employee, upon enrollment in the SHBP pursuant to this rule, who qualified for benefits under the provisions of N.J.S.A. 52:14-17.32f, 17.32f1 or 17.32f2 shall be eligible for coverage paid by the State;

5. Qualified retired employees of local or educational employers who are enrolled for coverage in that employer's plan and who enroll in the SHBP when the employer joins the SHBP;

6. Qualified retired employees of participating local employers who retired before the employer joined the SHBP but who enroll when offered coverage due to the employer's adoption of the provisions of P.L. 1979, c. 54 (N.J.S.A. 52:14-17.38);

7. Qualified retired employees of participating local employers who did not continue coverage into retirement but who elect to enroll in the SHBP when offered coverage due to the employer's adoption of the provisions of P.L. 1981, c. 436 (N.J.S.A. 52:14-17.38); and

8. Qualified retired employees under the provisions of P.L. 1997, c. 330 (N.J.S.A. 52:14-17.32i) codified at N.J.A.C. 17:9-6.9.

(c) "Retired employee" also means an employee whose coverage terminated prior to retirement, if that employee is awarded a disability retirement allowance. Eligibility for retired coverage in the SHBP shall begin on the employee's retirement date, but should the approval of the retirement allowance be delayed, coverage shall not be retroactive for more than one year.

(d) The definition of "retired employee" shall include the spouse or eligible domestic or civil union partner of an active or retired employee, provided the spouse or eligible partner was covered as a dependent under the SHBP immediately preceding the death of the active or retired employee, and further provided that in the case of death of an active employee, the spouse or eligible partner is receiving a periodic pension or survivorship benefit from a State or locally administered retirement system or plan.

(e) The definition of "retired employee" shall also include the spouse or eligible partner of the employee, provided the spouse or partner was eligible for coverage immediately preceding retirement and is enrolled for coverage when the employee retires or is added to coverage pursuant to N.J.A.C. 17:9-6.3(a).

(f) The definition of "retired employee" shall include an employee who is eligible to receive a Federal pension based upon employment with the Cooperative Extension service staff of Rutgers University. This coverage is contingent upon the employee applying for and receiving a Federal pension immediately following the cessation of employment and further provided that the pension to which the employee is entitled is being granted by reason of age or disability and coverage based on employment with Rutgers University.

(g) The definition of "retired employee" shall also include an employee who is eligible to receive a monthly annuity or long-term disability benefits based on the employee's participation in the New Jersey Alternate Benefit Program, provided the employee who is receiving a monthly annuity applied for and began receiving the annuity immediately following the termination of employment in a position covered by the Alternate Benefit Program.

(h) The definition of "retired employee" shall include any former employee, who retired from a State or locally administered retirement system or the spouse or eligible partner of the former employee of an employer who becomes a participating employer if the employee, spouse or eligible partner:

1. Is receiving a periodic retirement allowance or survivorship benefit from a State or locally administered retirement system;

2. Was insured under a group medical insurance plan of the employer immediately prior to the date the employer became a participating employer; and

3. Elects to enroll in the SHBP at the time the employer becomes a participating employer.

(i) The definition of "retired employee" shall include an employee who is eligible for continuation of coverage in the SHBP at the time of retirement who waives coverage at that time, or at a later date, because the employee has health benefit coverage (active or retired) through an employer or eligible retiree association as a dependent or as an active employee and who applies for continuation of coverage within 60 days after termination of coverage as a dependent or active employee. An eligible retiree association is an association whose membership is limited based on the employment of the employee or the employee's dependent. A certificate of continued coverage or employer or association letter certifying when coverage terminated must accompany the retiree application.

(j) 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 unless that employee is eligible for coverage under the provisions of P.L. 1987, c. 384 or P.L. 1992, c. 126 (N.J.S.A. 52:14-17.32f and 52:14-17.32f1).

(k) The employer liability for 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".
Amended by R.2000 d.494, effective December 18, 2000.
See: 32 N.J.R. 3385(a), 32 N.J.R. 4450(b).
Rewrote the section.
Amended by R.2005 d.187, effective June 20, 2005.
See: 37 N.J.R. 397(a), 37 N.J.R. 2212(b).
In (b), rewrote 4iii; in (d), (e) and (h), inserted "or eligible domestic partner" following "spouse" throughout; rewrote (i).
Amended as R.2006 d.290, effective August 21, 2006.
See: 38 N.J.R. 469(a), 38 N.J.R. 3316(a).
In (b)4ii and (b)4iii, substituted "Parts A and B of the" for "the full" and substituted "Program" for "program".
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In (a), substituted "SHBP's" for "State Health Benefits Program's"; in (b)2 and (b)3ii, deleted "employer-paid" following "eligible for"; in the introductory paragraph of (b)3, deleted "State Health Benefits Program (" preceding and a closing parenthesis following "SHBP"; in (b)3iii, deleted a comma following "Program", and substituted "c. 384" for "c.384", "c. 126" for "c.126" and "c. 357" for "c.357"; in (b)4iii, deleted ", either directly or through the retirement system or fund" from the end; in (b)5, (b)6, (b)7, (c), (d) and the introductory paragraph of (h)3, substituted "SHBP" for "State Health Benefits Program"; in (b)6, substituted "c. 54" for "c.54"; in (b)7, substituted "c. 436" for "c.436"; in (b)8, substituted "c. 330" for "c.330"; in (d), inserted "or civil union", and deleted "domestic" preceding the second and third occurrence of "partner"; in the introductory paragraph of (h), deleted "domestic" preceding "partner" twice; in (i), deleted "or terminates" following "who waives"; and in (j), substituted "c. 384" for "c.384" and "c. 126" for "c.126".

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 or denied by the Board of Trustees of the retirement system paying the benefit or by the investment 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, the local retirement system, or the investment 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, the retired employee's spouse or eligible partner who would be eligible to continue such coverage, retroactive coverage for no more than six months may be granted, provided that the retroactive and currently due premiums are received.

(b) Any employee, upon retirement, or an eligible survivor of such employee will be notified by regular mail of the right to continuous coverage in the SHBP. The retired employee or eligible survivor must, within a 30-day period following the receipt of the letter offering retired coverage, submit the appropriate application and, if required, the charges for such coverage. Any retired employee or eligible survivor not responding within the 30-day period shall receive a second notice. Any retired employee or eligible survivor not responding to the second notice within a 30-day period will not be permitted to enroll in the SHBP at a later date.

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."

Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.
Amended by R.2005 d.187, effective June 20, 2005.
See: 37 N.J.R. 397(a), 37 N.J.R. 2212(b).
In (a), inserted "or eligible domestic partner" following "spouse" in 3; in (b), inserted "or eligible domestic partner" following "eligible survivor" throughout.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In (a)1, deleted "of Pensions and Benefits" following "Division" and "or under the Alternate Benefits Program" from the end; in (a)3, deleted "domestic" preceding "partner"; and rewrote (b).

17:9-6.3 Retiree coverage; limitation

(a) A retiree, but not the retiree's surviving dependent, may change coverage to include a spouse, eligible partner and other dependents by submitting a completed application along with appropriate legal documentation, described at N.J.A.C. 17:9-3.3(a), verifying the dependent's relationship with the subscriber within 60 days of a change in family status (marriage, domestic partnership, civil union, birth or adoption of a child, or a significant change in health coverage due to a spouse's or partner's employment). The dependent shall be enrolled retroactively to the date of the qualifying event.

1. If a retiree, but not the retiree's surviving dependent, wishes to add an eligible spouse, eligible partner or dependent and the completed application and legal documentation is not received within 60 days of a family status change, there shall be a minimum waiting period of two full months upon the Division's receipt of a completed application and legal documentation to change coverage. A dependent may be enrolled as of the first day of the month following the two-month waiting period. A dependent added in this manner may be added to a retiree's contract only once.

(b) Retired employees, whose retirement allowance is less than the charge to be deducted to pay for the cost of the coverage for such retired employees, will be permitted to continue coverage provided that the retired employee pays for the cost of such coverage in advance on a monthly basis, in which case there will be no health benefit deduction from the retirement allowance.

(c) Any person who is otherwise eligible for benefits as a retired employee or dependent of a retired employee, but who, although eligible to enroll in the Federal Medicare program by reason of age or disability, is not covered by the Federal Medicare Part A and B coverage, is ineligible for coverage under the SHBP.

(d) A retired employee or dependent, who has maintained coverage in the SHBP following retirement and is subsequently removed from such coverage for not having the Federal Medicare Parts A and B coverage as required by statute, will be permitted to obtain prospective reentry into the SHBP once proof of Federal Medicare Part A and B coverage has been provided to the Division.

(e) In the event a retired employee or any dependent of a retired employee enrolls in a Medicare Part D plan, SHBP retiree prescription drug benefits shall immediately terminate for the retired employee and all dependents. However, enrollment in a Medicare Part D plan by a retired employee or any dependent of a retired employee will not affect the continuation of SHBP medical plan benefits for the retired employee and any dependent of the retired employee.

(f) In the event a retired employee or dependent of a retired employee has enrolled in a Medicare Part D plan, the retired employee and dependent(s) will be prospectively enrolled or re-enrolled for SHBP retiree prescription drug benefits provided:

1. The retired employee and dependent(s) have maintained SHBP medical plan coverage; and

2. The retired employee and, if applicable, the retired employee's dependent, terminates Medicare Part D plan coverage.

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.
Amended by R.1996 d.552, effective December 2, 1996.
See: 28 N.J.R. 3715(a), 28 N.J.R. 5079(a).
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.
Amended by R.2005 d.187, effective June 20, 2005.
See: 37 N.J.R. 397(a), 37 N.J.R. 2212(b).
In (a), rewrote the introductory paragraph and inserted ", eligible domestic partner" following "spouse" in 1; in (e), substituted "or dependent" for "and/or spouse".
Amended as R.2006 d.290, effective August 21, 2006.
See: 38 N.J.R. 469(a), 38 N.J.R. 3316(a).
Added (f) and (g).
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Rewrote the section.

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 Suspension of allowance

A retired employee, whose retirement allowance has been suspended, shall have his or her health insurance terminated upon the suspension of the allowance. Upon the reinstatement of the individual's allowance, coverage will resume.

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.
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.

17:9-6.5 Discontinuance of allowance

When a retired employee's or beneficiary's retirement allowance is discontinued, the retired employee's or beneficiary's coverage may be terminated upon such discontinuance. Upon the reinstatement of the individual's retirement allowance, health insurance coverage will be resumed and may be made retroactive to the date of reinstatement of the retirement allowance, but in no case for more than one year.

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".
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Inserted ", but in no case for more than one year".

17:9-6.6 Beneficiary, dependent or survivor

(a) An eligible beneficiary or survivor will have their coverage discontinued upon the death of the retired employee but will be given the opportunity to continue coverage. Coverage may be made retroactive for as much as six months provided the necessary charges are paid.

(b) An eligible surviving spouse or eligible partner will be offered the opportunity to continue participation in the SHBP 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. If the surviving spouse or partner is not the recipient of any monthly retirement allowance from a State-administered retirement system upon the death of the retired member, the Division will bill the surviving spouse or partner at the group rate.

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.
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.
Amended by R.2005 d.187, effective June 20, 2005.
See: 37 N.J.R. 397(a), 37 N.J.R. 2212(b).
In (b), inserted "or eligible domestic partner" preceding "will be offered" in the first sentence, and inserted "or domestic partner" preceding "is not the recipient" and "at the group rate" in the third sentence.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In (b), deleted "domestic" preceding "partner" throughout, substituted "SHBP" for "State Health Benefits Program", and deleted "of Pensions and Benefits" following "Division".

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

(a) For the purposes of this section, "eligible person" means the surviving spouse, eligible partner pursuant to N.J.A.C. 17:1-5.5 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, eligible partner 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 SHBP 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 surviving spouse or eligible partner, eligible children shall participate as dependents of the surviving spouse or partner. If there is no surviving spouse or partner, 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).
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
In (a), substituted "surviving spouse" for "widow or widower" preceding "and child"; in (c), deleted references to widow or widower.
Amended by R.2005 d.187, effective June 20, 2005.
See: 37 N.J.R. 397(a), 37 N.J.R. 2212(b).
In (a), substituted "surviving spouse, eligible domestic partner pursuant to N.J.A.C. 17:1-5.5 and child" for "surviving spouse and child" preceding ", as defined in N.J.S.A. 43:16A-1" and inserted "eligible

domestic partner" preceding "and child, as defined in N.J.S.A. 53:5A-3"; in (c), inserted references to domestic partners following references to spouses throughout.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In (a) and (c), deleted "domestic" preceding "partner" throughout; in (b), substituted "SHBP" for "State Health Benefits Program" and "c. 271" for "c.271"; and in (c), inserted a comma following "continue".

17:9-6.8 Premium-sharing for retired employee State Health Benefit Coverage and reimbursement for Medicare Part B costs

(a) All State employees, except nonaligned uniformed State Police officers, who accrue 25 years of service credit in a State-administered retirement system or retire on a disability retirement after July 1, 1997, for whom there is no majority representative for collective negotiations purposes, and who were hired by the State prior to July 1, 1995, shall, upon retirement, receive Medicare Part B reimbursement after retirement up to a cap of $46.10 per month per eligible employee and the employee's spouse or eligible partner and be subject to payroll deductions for coverage in advance of the coverage period in accordance with standard payroll procedures as set forth below. State employees, except nonaligned uniformed State Police officers, who accrue 25 years of service credit in a State-administered retirement system or who retire on a disability retirement after July 1, 1997, for whom there is no majority representative for collective negotiations purposes, and who were hired by the State on or after July 1, 1995, shall not be entitled to receive Medicare Part B reimbursement after retirement.

(b) For employees hired before December 11, 1995, who accrue 25 years of service credit in a State-administered retirement system or retire on a disability retirement after July 1, 1997 but before July 1, 2000, payroll deductions for NJ DIRECT10 coverage shall be determined using a base salary as of the first pay period of the calendar year in which retirement occurred, as follows:

1. Upon retirement, retirees with a base salary of $40,000 or more in the year of retirement shall pay the difference between the cost of the NJ DIRECT10 and the average cost for NJ DIRECT15 and participating HMOs as determined hereinafter.

2. Upon retirement, retirees with a base salary of less than $40,000 in the year of retirement shall pay, on a monthly basis, one percent of the base salary but not less than $20.00 per month.

(c) Employees hired on or after December 11, 1995 who accrue 25 years of service credit in a State-administered retirement system after July 1, 1997 but before July 1, 2000 or retire on a disability retirement after July 1, 1997 but before August 1, 2000, shall, upon retirement, pay the difference between the cost of NJ DIRECT10 and the average cost to the State for NJ DIRECT15 and participating HMOs as determined hereinafter.

(d) The average cost for NJ DIRECT15 and participating HMOs for each category of coverage for a rate time period shall be determined as follows:

1. Multiply the number of retirees who elected the category of coverage at the beginning of the rate time period immediately preceding the current rate time period by the premium or periodic charge rate for the category of coverage for the current rate time period for NJ DIRECT15 and each participating HMO.

2. Determine the total premium and periodic charges for all retirees who elected the category of coverage by adding the amounts determined under (d)1 above for NJ DIRECT15 and the participating HMOs.

3. Divide the total premium and periodic charges for all retirees who elected the category of coverage determined under (d)2 above by the total number of retirees who elected the category of coverage at the beginning of the immediately preceding rate time period for NJ DIRECT15 and the participating HMOs.

(e) For retirees who accrue 25 years of service credit in a State-administered retirement system on or after July 1, 2000 but before June 30, 2007 or retire on a disability retirement after July 1, 2000 but on or before July 1, 2007, payroll deductions for NJ DIRECT10 coverage shall be determined as follows:

1. Retirees electing NJ DIRECT10 shall pay 25 percent of the cost of that plan's premium as established by the Commission pursuant to N.J.S.A. 52:14-17.32b;

2. Retirees electing NJ DIRECT15 or an HMO shall have no premium payment; and

3. For State retirees who accrue 25 years of service credit in a State-administered retirement system on or after July 1, 2007, or retire on a disability retirement after July 1, 2007, shall pay a health contribution for NJ DIRECT15 or HMO coverage of 1.5 percent of their retirement allowance, as negotiated, or 1.5 percent of 50 percent of the highest salary received in the last five years of employment for Alternate Benefit Program members. The health contribution is waived for retirees who participate in the Retiree Wellness Program. Retirees must elect to participate in the Retiree Wellness Program within 60 days of the date of retirement. If the Retiree Wellness Program is not elected within this time period, the retiree will be required to pay the health contribution of 1.5 percent of the retirement benefit. Retirees not electing to participate in the program when first eligible may elect to participate in the Retiree Wellness Program only during the Division's annual open enrollment.

(f) The premium-sharing obligations for retired nonaligned uniformed State Police officers shall be the same as those for retired Lieutenants of the Division of State Police.

(g) Independent State authorities, boards, commissions, corporations, agencies or organizations who are excluded from determining by means of a binding collective negotiations agreement the payment obligations of the employer to pay the premium or periodic charges for SHBP coverage in retirement under the provisions of N.J.S.A. 52:14-17.38, and who are permitted by N.J.S.A. 52:14-17.28b to have their active employees premium share in the same manner as the State, may also have their retired employees premium share in the same manner as the State. The payment obligations of an employee under this subsection shall be the payment obligations applicable to the employee on the date the employee retired on a disability pension or the date the employee meets the service credit and service requirements for employer payment for the coverage, as the case may be.

New Rule, R.1998 d.265, effective June 1, 1998.
See: 30 N.J.R. 803(a), 30 N.J.R. 2070(a).
Amended by R.2000 d.298, effective July 17, 2000.
See: 32 N.J.R. 1322(a), 32 N.J.R. 2601(b).
In (b), inserted "but before July 1, 2000," in the introductory paragraph; in (c), substituted "after July 1, 1997, but before July 1, 2000 or retire on a disability retirement after July 1, 1997 but before August 1, 2000" for "or retire on a disability retirement after July 1, 1997" following "system"; and added (e).
Amended by R.2003 d.184, effective May 5, 2003.
See: 35 N.J.R. 86(a), 35 N.J.R. 1924(a).
Rewrote (a); in (e)2, deleted ", the State of New Jersey Managed Care/Point of Service Plan," following "NJ PLUS"; added (f).
Amended by R.2005 d.187, effective June 20, 2005.
See: 37 N.J.R. 397(a), 37 N.J.R. 2212(b).
In (a), inserted "or eligible domestic partner" following "the employee's spouse" in the first sentence; added (g).
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Substituted "DIRECT15" for "PLUS" throughout; in (a), deleted "domestic" preceding "partner" and "Traditional Plan" preceding the first occurrence of "coverage"; in the introductory paragraph of (b), (b)1, (c), the introductory paragraph of (e), and (e)1, substituted "NJ DIRECT10" for "Traditional Plan"; in the introductory paragraph of (b), inserted "using a base salary as of the first pay period of the calendar year in which retirement occurred, as follows"; in (c), inserted a comma following "shall" and "upon retirement"; in the introductory paragraph of (e), inserted "but before June 20, 2007" and "but on or before July 1, 2007"; in (e)1, deleted "and" from the end; in (e)2, substituted "; and" for a period at the end; and added (e)3.

17:9-6.9 Eligibility for State payment of retiree coverage under P.L. 1997, c. 330

(a) For the purposes of this section, "qualified retiree" means a person who:

1. Is a retiree from:

i. The Police and Firemen's Retirement System of New Jersey (N.J.S.A. 43:16A-1 et seq.), hereinafter referred to as PFRS;

ii. The Consolidated Police and Firemen's Pensions Fund (N.J.S.A. 43:16-1 et seq.), hereinafter referred to as CPFPF; or

iii. The Public Employees' Retirement System of New Jersey (N.J.S.A. 43:15A-6 et seq.), hereinafter referred to as PERS, from a position included in the definition of "law enforcement officer" under section 1 of P.L. 1955, c. 257 (N.J.S.A. 43:15A-97), from a PFRS-covered position that would have made the member eligible for enrollment in the PFRS but for age, from a position that would have been eligible for enrollment in the PFRS had the employer joined the PFRS by referendum under the provisions of N.J.S.A. 43:16A-3(2) or from a position that is eligible for participation in PFRS as provided in section 9 of P.L. 1989, c. 204 (N.J.S.A. 43:16A-1.2);

2. Retired on a benefit based on 25 or more years of service credit or on disability retirement under PFRS, CPFPF, or PERS;

3. Was eligible to receive health benefits coverage at the expense of the employer immediately preceding retirement; and

4. Is not eligible for employer payment of health benefits coverage after retirement, regardless of whether the employer pays for health benefits coverage for other retirees.

(b) Pursuant to P.L. 1997, c. 330 (N.J.S.A. 52:14-17.32i et seq.), a qualified retiree and his or her eligible dependents, as defined in section 2 of P.L. 1961, c. 49 (N.J.S.A. 52:14-17.26), but not survivors, are eligible to participate in the SHBP in accordance with the laws and rules governing the program, regardless of whether the retiree's employer participated in the program, and for State payment of an amount of the premium or periodic charges for the category of coverage elected by the qualified retiree equal to 80 percent of the premium or periodic charges for that category of coverage under the State-managed care plan or health maintenance organization, which provides services in the 21 counties of the State and the lower premium or periodic charges.

(c) The following persons are not eligible for benefits under P.L. 1997, c. 330 (N.J.S.A. 52:14-17.32i et seq.).

1. A retired State employee whose premium or periodic charges for health benefits under the SHBP are paid by the State pursuant to section 8 of P.L. 1961, c. 49 (N.J.S.A. 52:14-17.32) or section 6 of P.L. 1996, c. 8 (N.J.S.A. 52:14-17.28b);

2. A retiree of an employer other than the State for whom the employer pays any amounts for health benefits under the SHBP, including Medicare B reimbursements, as authorized by section 7 of P.L. 1964, c. 125 (N.J.S.A. 52:14-17.38) and pursuant to a collective negotiations agreement, ordinance, or resolution on or after July 1, 1998;

3. A retiree of an employer other than the State for whom the employer pays any amounts for health benefits as authorized by N.J.S.A. 40A:10-23, including Medicare B reimbursements, and pursuant to a collective negotia-

tions agreement, ordinance, or resolution, for the life of the retiree, on or after July 1, 1998;

4. A retiree of an employer other than the State for whom the employer pays any amounts for health benefits as authorized by N.J.S.A. 40A:10-23, including Medicare B reimbursements, and pursuant to a collective negotiations agreement, ordinance, or resolution, for a period of time less than the life of the retiree while the employer is paying any amounts for health benefits, on or after July 1, 1998;

5. A retiree otherwise eligible for State payment of health benefits under the SHBP pursuant to N.J.S.A. 52:14-17.32i et seq. who is receiving health benefits coverage from an employer in connection with employment after retirement while the retiree is receiving the coverage; and

6. A retiree of an employer other than the State who would have been ineligible for State payment for health benefits under the SHBP pursuant to N.J.S.A. 52:14-17.32i et seq. because of employer payment for health benefits coverage after retirement for the collective negotiations unit, the employment classification or the category, of which the retiree was a member, under a negotiated agreement, ordinance, or resolution on July 1, 1998, and who otherwise meets the eligibility requirements for the benefit as a result of a change in the negotiated agreement, ordinance, or resolution after July 1, 1998.

(d) A qualified retiree who is ineligible for benefits under N.J.S.A. 52:14-17.32i et seq. because of employer payment for retiree coverage under (c)4 above or receipt of health benefits coverage in connection with employment after retirement under (c)5 above, shall be eligible for the benefits after termination of employer payment for retiree coverage or employer coverage if the retiree applies to the SHBP for the benefits within 60 days after the effective date of termination of employer payment or coverage. A certificate of continued coverage or employer letter certifying when coverage terminated must accompany the retiree application.

(e) The surviving spouse or eligible partner of a retiree who was eligible or was enrolled for benefits under N.J.S.A. 52:14-17.32i et seq., shall be eligible to continue coverage, at full cost, in the SHBP. If the deceased retiree would have been eligible for such coverage but was not enrolled due to active health benefit coverage as an employee or dependent, the surviving spouse or eligible partner may enroll in the SHBP, on a prospective basis, within six months after the retiree's death. The surviving spouse or eligible partner must inform the SHBP that they wish to enroll for coverage and must fill out an enrollment form and pay the required premiums before coverage may become effective.

(f) A qualified retiree who waives coverage at retirement, or at a later date, due to health benefit coverage (active or retired) through an employer as a dependent shall be eligible for the benefits after termination of dependent coverage if the retiree applies to the SHBP for the benefits within 60 days after the effective date of termination of dependent coverage. A certificate of continued coverage or employer letter certifying when coverage terminated must accompany the retiree application.

New Rule, R.1999 d.373, effective November 1, 1999.
See: 31 N.J.R. 2300(b), 31 N.J.R. 3524(b).
Amended by R.2000 d.495, effective December 18, 2000.
See: 32 N.J.R. 3387(a), 32 N.J.R. 4451(a).
In (a)1, rewrote iii.
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote (c); added (e).
Amended by R.2005 d.187, effective June 20, 2005.
See: 37 N.J.R. 397(a), 37 N.J.R. 2212(b).
In (d), added the last sentence; in (e), inserted "or dependent" following "an employee" in the second sentence and inserted "or eligible domestic partner" preceding "surviving spouse" throughout; added (f).
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Section was "Eligibility for State payment of retiree coverage under P.L. 1997, c.330". In (a)1iii, substituted "c. 257" for "c.257", "PRFS-covered" for "PRFS covered" and "c. 204" for "c.204"; in (b), substituted "c. 330" for "c.330", "c. 49" for "c.49" and "State-managed" for "State managed", and deleted "State Health Benefits Program (" preceding and a closing parenthesis following "SHBP"; in the introductory paragraph of (c), substituted "c. 330" for "c.330"; in (c)1, substituted "SHBP" for "State Health Benefits Program", "c. 49" for "c.49" and "c. 8" for "c.8"; in (c)2, substituted "c. 125" for "c.125"; and in (e), deleted "domestic" preceding "partner" throughout, inserted a comma following "et seq." and substituted "SHBP" for "State Health Benefits Program".

Case Notes

Initial Decision (2005 N.J. AGEN LEXIS 571) adopted, which cancelled a retired former public employee's enrollment in the State Health Benefits Plan where the employee, pursuant to a collective bargaining agreement in effect when the employee retired, called for the employee's employer to provide health insurance for retirees. Under this section, any retiree receiving health benefits coverage from an employer was ineligible for benefits under the Plan and no distinction was made between employees receiving full coverage and those who only had a limited benefit. In re Kosakowski, OAL DKT No. TYP 2028-04S, 2005 N.J. AGEN LEXIS 1352, Final Decision (November 17, 2005).

17:9-6.10 Retiree prescription drug plan

(a) The following terms, as used in this section, shall have the following meanings:

"Brand name" means the proprietary or trade name assigned to a drug product by the manufacturer or distributor of the drug product.

"Generic drug products" means prescription drug products and insulin approved and designated by the U.S. Food and Drug Administration as therapeutic equivalents for reference listed drug products. It includes drug products listed in the New Jersey Generic Formulary by the Drug Utilization Review Council pursuant to N.J.S.A. 24:6E-1 et seq.

"Mail-order pharmacy" means the mail order program available through the provider.

"Preferred brands" means brand name prescription drug products and insulin determined by the provider, to be more cost effective alternatives for prescription drug products and insulin with comparable therapeutic efficacy within a therapeutic class, as defined or recognized in the United States

Pharmacopeia or the American Hospital Formulary Service Drug Information, or by the American Society of Health Systems Pharmacists. A drug product for which there is no other therapeutically equivalent drug product shall be a preferred brand. Determinations of preferred brands by the provider shall be subject to review and modification by the Commission.

"Prescription drug plan" means the plan for providing payment for eligible prescription drug expenses of retired

members of the State Health Benefits Program and their eligible dependents who participate in the Traditional Plan or the State managed care plan (NJ PLUS) as prescribed by this section. Upon the effective date of the contracts to implement the successor or replacement plans for the Traditional Plan and NJ PLUS pursuant to the provisions of P.L. 2007, c. 103, "prescription drug plan" shall mean the plan or plans providing payment for eligible prescription drug expenses for all State Health Benefit Program retirees and their eligible dependents.

"Provider" means an insurance company, hospital, medical, or health service corporation, pharmacy benefit manager, or health maintenance organization under agreement or contract with the Commission to administer the prescription drug plan.

"Retail pharmacy" means a pharmacy, drug store or other retail establishment in this State at which prescription drugs are dispensed by a registered pharmacist under the laws of this State, or a pharmacy, drug store or other retail establishment in another state at which prescription drug products are dispensed by a registered pharmacist under the laws of that state if expenses for prescription drug products dispensed at the pharmacy, drug store or other retail establishment are eligible for payment under the prescription drug plan.

"Other brands" means prescription drug products which are not preferred brands or generic drug products. A new drug product approved by the U.S. Food and Drug Administration which is not a generic drug product shall be included in this category until the provider makes a determination concerning inclusion of the drug product in the list of preferred brands.

(b) Reimbursement for the co-payments required under the prescription drug plan shall not be made under the medical portion of any SHBP plan. There shall be no annual deductible amount that retired members or their eligible dependents shall satisfy before eligibility for payment of prescription drug expenses under the prescription drug plan.

(c) Eligibility of prescription drug expenses for coverage under the prescription drug plan shall be determined on the same basis as reasonable and necessary medical expenses under the State Health Benefits Program.

(d) A co-payment shall be required for each prescription drug expense until a retired member or eligible dependent satisfied the maximum annual out-of-pocket expense for a calendar year prescribed in (g) and (h) below. The initial amounts of the co-payments for calendar years 2000 and 2001 shall be as follows:

Type of Drug Product	Retail Pharmacy	Mail-Order Pharmacy
Generic	$ 5.00	$ 5.00
Preferred Brands	$10.00	$15.00
Other Brands	$20.00	$25.00

(e) The supply of a drug product eligible for coverage under the prescription drug plan for each prescription drug expense shall be limited to 30 days if the prescription is filled at a retail pharmacy, and 90 days if the prescription is filled through the mail-order pharmacy.

(f) The co-payment amounts under (d) above shall be reviewed annually and shall be increased by the rate of increase of the average wholesale price for a one-day supply of prescription drug products covered under the prescription drug plan for the immediately preceding fiscal year over the second preceding fiscal year rounded to the nearest whole dollar. The basis for determining an increase in the amounts of co-payments from year to year from the initial amounts shall be the actual results of the calculations to determine the increased amounts, and not the rounded amounts of co-payments applicable for any year or years. The co-payments shall be reviewed initially for calendar year 2002. Since there will not be a full fiscal year of experience for fiscal year 2000 under the prescription drug plan, the experience for fiscal year 2000 shall be annualized on an actuarial basis. The rate of increase in the co-payment amounts for calendar years 2002 and 2003 shall not exceed seven percent.

(g) The amount of out-of-pocket expense that a retired member or eligible dependent shall pay for a calendar year for eligible prescription drug expenses under the prescription drug plan shall be limited initially for calendar years 2000 and 2001 to $300.00.

(h) The maximum amount of annual out-of-pocket expense under (g) above shall be reviewed annually and shall be increased by the rate of increase in the amount of prescription drug expenses paid per member under the prescription drug plan for the immediately preceding fiscal year over the second preceding fiscal year rounded to the nearest whole dollar. The maximum amount of annual out-of-pocket expense shall be reviewed initially for calendar year 2002. Since there will not be a full fiscal year of experience for fiscal year 2000 under the prescription drug plan, the experience for fiscal year 2000 shall be annualized on an actuarial basis. The rate of increase in the maximum amount of annual out-of-pocket expense for calendar years 2002 and 2003 shall not exceed 15 percent.

(i) Notice of increases in the amounts of the co-payments and the maximum out-of-pocket expense shall be published in the New Jersey Register and shall be sent to all retirees affected by the increases.

(j) The provider administering the prescription drug plan shall comply with N.J.A.C. 11:4-37.3(c)1 through 4, 6 and 7 in administration of the prescription drug plan.

(k) The Commission may limit the annual increases in the co-payments and the maximum out-of-pocket expense for the following reasons:

1. To limit excessive annual increases which are significantly higher than the trends for the increases over the preceding five years;

2. To maintain an appropriate spread between the categories of co-payment amounts; or

3. To prevent undue hardship to retirees if general economic circumstances in the State or economic circumstances relative to health care for retirees are such that strict application of the formulas for the annual increases in the co-payments or the maximum out-of-pocket expense would produce such hardship.

(*l*) For calendar year 2006 (January 1, 2006 through December 31, 2006), the out-of-pocket maximum expense limit shall be equivalent to $1,000. For each calendar year thereafter the out-of-pocket maximum expense limit shall be recalculated pursuant to the provisions of (h) above.

New Rule R.2000 d.116, effective March 20, 2000.
See: 31 N.J.R. 4235(a), 32 N.J.R. 1048(a).
Notice of increase in co-payments and maximum out-of-pocket expenses, effective January 1, 2002.
See: 33 N.J.R. 3774(a).
Public Notice: Notice of increase in co-payments and out-of-pocket expenses, effective January 1, 2004.
See: 35 N.J.R. 4791(b).
Public Notice: Notice of increase in the amounts of co-payments and the maximum out-of-pocket expenses under the retiree prescription drug card plan.
See: 37 N.J.R. 363(b).
Amended by R.2005 d.62, effective February 22, 2005.
See: 36 N.J.R. 4691(a), 37 N.J.R. 627(a).
In (b), substituted "six" for "five" and "2006" for "2005" and substituted references to prescription drug plan for card plan.
Amended by R.2006 d.39, effective January 17, 2006.
See: 37 N.J.R. 3947(a), 38 N.J.R. 829(b).
In (b), deleted "for six years (" and substituted "December 31, 2007" for "March 20, 2006"; added (*l*).
Amended by R.2008 d.347, effective November 17, 2008.
See: 40 N.J.R. 104(a), 40 N.J.R. 6651(a).
In definition "Prescription drug plan" in (a), inserted the last sentence; in definition "Provider" in (a), inserted "pharmacy benefit manager,"; in (b), deleted the former first and second sentences and inserted the current first sentence; and in (c), substituted "State Health Benefits Program" for "major medical portion of the Traditional Plan and NJ PLUS".

17:9-6.11 Aggregation of nonconcurrent pension credit to qualify for employer-paid retired SHBP benefits under P.L. 2001, c.209

(a) To qualify for employer-paid SHBP coverage based on combined service in more than one New Jersey public retirement systems, members must:

1. Retire and collect a benefit from each retirement system;

2. Have 25 or more years of nonconcurrent pension service credit in total;

3. Retire from the last retirement system after the effective date of P.L. 2001, c.209, August 15, 2001;

4. Be eligible for employer-paid SHBP coverage immediately prior to retirement from the last contributing employer in the retirement system for retirees of the State or participating local employers. Retirees of the State or participating local employers, except school boards and county colleges, are not eligible for SHBP coverage if they elect a deferred retirement benefit; or

5. Be eligible for employer-paid coverage immediately prior to retirement or separation from a school board or county college in New Jersey. The school board or county college must have been the retiree's last contributing employer in order to receive State-paid SHBP coverage as a retiree of a school board or county college.

(b) In addition to meeting one of the criteria in (a) above, in order to qualify, a member must also notify the Division of Pensions and Benefits that they have an aggregate of 25 or more years of nonconcurrent service in more than one public retirement system in New Jersey. Employer-paid coverage will be effective on the first of the month following the date the eligible member notifies the Division.

(c) The provisions of P.L. 2001, c.209 do not affect the definition of a qualified retiree under the provisions of P.L. 1997, c.330 (see N.J.A.C. 17:9-6.9).

New Rule, R.2003 d.185, effective May 5, 2003.
See: 35 N.J.R. 87(a), 35 N.J.R. 1925(a).

SUBCHAPTER 7. TERMINATION

17:9-7.1 Termination effective date

(a) Cessation of active SHBP employee coverage shall be deemed to occur on the last day of eligibility for the coverage period for which charges have been paid.

(b) If a SHBP subscriber does not remit payment by the end of the month in which payment is due and owing, the SHBP shall notify the member by regular mail that the right to continue coverage will be suspended if payment in full is not remitted within 30 days of the suspension notice. If no payment is made, the SHBP shall generate a notice of termination to the member indicating the termination date and restating the amounts due to reinstate coverage. Termination shall be effective on the last day of the month for which premiums were paid. The SHBP shall not reinstate the member unless the member remits the entire balance due. Once coverage terminates, reinstatement is not automatic and will only be done after a review of the individual's circumstances by the SHBP.

(c) Unless the subscriber requests termination of coverage, SHBP coverage for a member who is awaiting approval of a retirement benefit shall continue until the retirement is either approved or denied provided the member makes the appropriate remittance for coverage. Any retroactive SHBP premiums owed by the subscriber shall be deducted from the

retirement benefit when approved, the withdrawal check, the return of pension contributions, or from any retirement or death benefit received by the member's surviving dependent.

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".
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.
Amended by R.2005 d.187, effective June 20, 2005.
See: 37 N.J.R. 397(a), 37 N.J.R. 2212(b).
Rewrote (c).
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In (c), inserted "provided the member makes the appropriate remittance for coverage", and deleted "spouse, domestic partner or" preceding "dependent".

17:9-7.2 Termination of eligibility

(a) The coverage of an employee and such employee's eligible dependents shall terminate whenever such employee's eligibility shall cease for any of the reasons given in (c) below.

(b) The effective date of termination shall be the last day of the coverage period corresponding to the payroll period or month in which the last payroll deduction was made from the employee's salary for coverage, if any are required, or the last charge shall have been paid by the State for the employee's and/or the employee's dependents' coverage or by the local employer for the employee and/or the employee's dependents, as the case may be.

(c) Coverage for the employee and the employee's dependents will terminate if:

1. The subscriber voluntarily terminates coverage;

2. The employee terminates employment;

3. The employee's hours are reduced so the employee no longer qualifies for coverage as a full-time employee. An employee whose coverage terminated as a result of a change from full-time to part-time status cannot be reenrolled until the employee has reestablished eligibility for coverage by serving the normal waiting period prescribed for new enrollees. In no event will the waiting period include any part-time service rendered by the employee;

4. The employee is on a leave of absence and the employee does not make required premium payments. The coverage of an eligible employee and of an employee's dependents during any period of authorized leave of absence without pay shall terminate on the last day of the second coverage period following the last payroll period or month for which the employee received a salary payment if the total charge for the coverage is not paid by the employee;

5. The employee enters the Armed Forces, is eligible for government-sponsored health services and is not receiving differential pay from the State or local employer;

6. The subscriber's employer ceases to participate in the SHBP;

7. The subscriber dies;

8. The employee is suspended; or

9. The employee is on a furlough or extended furlough and fails to make required premium payments in advance.

(d) In addition to the above, coverage for dependents will end if:

1. The dependent no longer meets the SHBP definition of an eligible dependent found at N.J.A.C. 17:9-3.1;

2. The dependent dies;

3. The dependent enters the Armed Forces;

4. The subscriber fails to make required premium payment(s) for dependents; or

5. The dependent child becomes eligible for SHBP coverage due to employment.

As amended, R.1973 d.8, effective January 4, 1973.
See: 4 N.J.R. 282(a), 5 N.J.R. 59(b).
As amended, R.1979 d.261, effective July 3, 1979.
See: 11 N.J.R. 208(b), 11 N.J.R. 415(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 "his" to "his or her".
Amended by R.1989 d.336, effective July 3, 1989.
See: 21 N.J.R. 886(b), 21 N.J.R. 1836(b).
Reenrollment provisions added at (c)6.
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In (d)3, deleted "or" from the end; in (d)4, substituted "; or" for a period at the end; and added (d)5.

Cross References

See sections 4.2 (State; full-time defined) and 4.6 (Local; full-time defined) of this chapter in reference to the limited continuation of coverage while on sabbaticals.

17:9-7.3 Continuation of coverage

(a) The coverage of an employee, and an employee's dependents, may be continued if:

1. The employee has an award pending or received an award of periodic benefits under Workers' Compensation and the employee is not otherwise covered as an employee or retiree under the SHBP. The employee may continue coverage and the coverage of the employee's dependents, provided that the employee shall pay to the employer in advance that portion, if any, of the charges due from the employee to continue the coverage;

2. The employee is on an approved leave of absence without pay. The coverage of such employee and such employee's dependents may be continued by such employee,

provided that the employee shall pay in advance the total charge required for the employee's coverage and coverage of the employee's dependents during such period of authorized leave of absence without pay; provided that no period of continued coverage, as provided above, shall exceed a total of 20 biweekly payroll periods, or nine months, during which the employee receives no pay. After the 20 biweekly payroll periods, or nine months, the employee may continue coverage through COBRA for the remaining balance of the COBRA continuation period; or

3. The employee is on an approved State or Federal Family Leave.

i. The State Family Leave Act (N.J.S.A. 34:11B-1 et seq.) entitles an employee to continue 12 weeks of SHBP coverage in any 24-month period at the expense of their employer. This includes all health care benefits, including Prescription Drug, Dental and Vision Care benefits if the employer provides them. State Family Leave includes leave from employment to provide care for the birth or adoption of a child, or the serious illness of a child, parent, spouse or partner. It does not provide for a leave due to the personal illness of the employee.

ii. The Federal Family Leave Act (Family and Medical Leave Act of 1993, 29 U.S.C. §§ 2601 et seq.) has benefits similar to the State Family Leave Act with the exception that the Federal act also requires that leave be permitted for the employee's own serious illness of up to 12 weeks in any 12-month period.

iii. In cases where the employee on an approved Family Leave has a deduction, the employer must make arrangements with the employee to receive direct payment for the required employee contribution. If the SHBP does not receive full payment from the employer, then the employee's benefit coverage will be terminated under the termination provisions of the SHBP program.

iv. The time an employee spends on Federal or State family leave shall not count as part of the COBRA eligibility period should an employee receive approval from their employer to extend the leave.

Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In (a)1, substituted "SHBP" for "State Health Benefits Program"; and in (a)3i, substituted a comma for "or" preceding "spouse" and inserted "or partner".

17:9-7.4 Voluntary termination

A subscriber may elect voluntarily to terminate coverage for the subscriber or the subscriber's dependents at any time, but termination of the subscriber's own coverage shall automatically terminate the coverage of the subscriber's dependents. Such voluntary termination shall be effected by written notice thereof to the State Health Benefits Bureau by use of the New Jersey SHBP application. Coverage may be reinstated for active employees after termination for the eligible employee and eligible dependents in accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and during any subsequent open enrollment period. Coverage may be reinstated for retirees after termination of the retiree and eligible dependents only as permitted in N.J.A.C. 17:9-6.

As amended, R.1978 d.442, effective December 26, 1978.
See: 10 N.J.R. 456(a), 11 N.J.R. 105(b).
As amended, R.1983 d.44, effective March 7, 1983.
See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).
Reference to female employees added.
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Substituted "SHBP" for "State Health Benefits Program" and "N.J.A.C. 17:9-6" for "Subchapter 6".

SUBCHAPTER 8. EMPLOYEE PRESCRIPTION DRUG PLAN

17:9-8.1 Employee Prescription Drug Plan

(a) The Employee Prescription Drug Plan was established under the provisions of N.J.S.A. 52:14-17.29(F).

(b) Separate election shall be required for enrollment and for a change in, or a termination of, coverage in the Employee Prescription Drug Plan.

(c) The rules for eligibility and for determining the effective dates of coverage are the same as those of the SHBP as administered by the Commission in accordance with the provisions of N.J.S.A. 52:14-17.25 et seq. with the following exceptions:

1. Except under the provisions of the Federal COBRA law, prescription drug coverage is not continued in the event of death, retirement, or other termination of the group coverage;

2. Employers, other than the State of New Jersey, may offer to their employees and eligible dependents enrollment in the State Employee Prescription Drug Plan, or another free-standing prescription drug plan, or elect to have prescription drug coverage under the offering of their SHBP medical plans.

i. If the employer elects to offer a free-standing prescription drug plan, the employee's share of the cost for this prescription drug plan may be determined by a formula different from that used to determine the employee's share of the cost of health coverage. The employee may pay a share of the cost of prescription drug coverage for the employee and for the employee's covered dependents as required by a bargaining unit agreement. The employer may establish by ordinance or

resolution, rules for the employee's share of the cost for those employees not covered under a bargaining agreement.

ii. If an employer, other than the State of New Jersey, offers a free-standing prescription drug plan other than the State Employee Prescription Drug Plan, this plan must be comparable in design, as determined by the Commission, to the State Employee Prescription Drug Plan. If an employee declines the employer's offering of a prescription drug plan, no reimbursement for prescription drugs will be provided under the SHBP medical plan in which the member is enrolled; and

3. Prescription drug classifications that are not eligible for coverage under the employer's prescription drug plan are also not eligible for coverage under the SHBP medical plans except as Federally or State mandated.

Repeal and New Rule, R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Section was "State Prescription Drug Program comparable to State Health Benefits Program".
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In the introductory paragraph of (c), substituted "SHBP" for "State Health Benefits Program", and deleted "State Health Benefits" preceding "Commission"; deleted former (c)2, recodified former (c)3 and (c)4 as (c)2 and (c)3; in the introductory paragraph of (c)2, substituted "SHBP" for "State Health Benefits Program"; in (c)2ii, substituted the second occurrence of "plan" for the second occurrence of "Plan" and "SHBP" for "State Health Benefits Program"; and in (c)3, substituted "SHBP" for "State Health Benefits Program".

17:9-8.2 Prescription drug cards

Identification cards shall be issued by the carrier upon initial enrollment or change of coverage. Identification cards may be reissued periodically. For State employees, each issue may reflect the bargaining unit in which the State employee participates. All cards will be mailed directly to the subscriber's home whenever possible. Otherwise, cards are to be distributed through the payroll and personnel officers.

Recodified from 17:1-10.2 and amended by R.1993 d.268, effective August 2, 1993.
See: 25 N.J.R. 675(b), 25 N.J.R. 3506(b).
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.

17:9-8.3 Termination; effective date

(a) The effective date of termination shall be the last day of the coverage period corresponding to the payroll period or month in which the last payroll deduction was made from the employee's salary for the coverage, if any are required, or the last charge shall have been paid by the State for employee's and/or his or her dependents' coverage or by the local employer for the employee and/or his or her dependents, as the case may be. Coverage may continue under the conditions set forth in N.J.A.C. 17:9-7.3.

(b) Eligibility shall be terminated in accordance with the provisions of N.J.A.C. 17:9-7.2.

New Rule, R.1993 d.268, effective August 2, 1993.
See: 25 N.J.R. 675(b), 25 N.J.R. 3506(b).
Amended by R.1995 d.3, effective January 3, 1995.
See: 26 N.J.R. 2202(a), 27 N.J.R. 128(a).
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
In (a), added the second sentence; in (b), substituted N.J.A.C. reference for "as follows" in the introductory paragraph and deleted 1 through 6.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In (a), deleted "of dependents" following "salary for the coverage".

SUBCHAPTER 9. EMPLOYEE DENTAL PLANS

17:9-9.1 Employee Dental Plans

(a) The Employee Dental Plans were established under the provisions of N.J.S.A. 52:14-17.29(F) and were extended to local participating employers as of January 1, 2005. The Employee Dental Plans are available to full-time employees and their eligible dependents. Newly eligible employees may enroll by completing an application during the first 60 days of employment. The Employee Dental Plans offer a choice between two types of dental plans; a Dental Expense Plan and a Dental Plan Organization (DPO). The Dental Expense Plan is a traditional indemnity-type plan which allows the employee to select any licensed dentist for dental care. The Dental Plan Organizations (DPOs) are companies that contract with a network of providers for dental services. The employee must use providers participating with the DPO selected.

(b) The Plans are voluntary. A separate election will be required for enrollment and for a change in, or a voluntary termination of, coverage in the Employee Dental Plans.

(c) The rules are the same as those of the SHBP as administered by the Commission in accordance with the provisions of N.J.S.A. 52:14-17.25 et seq. with the following exceptions:

1. Duplicate coverage is not permitted; an individual may be covered as an employee or as a dependent or retiree, but not as both an employee and a dependent or retiree. Dependent children may only be covered by one parent;

2. Coverage may be continued during an approved leave of absence without pay of not more than three months (six biweekly pay periods) provided the employee pays the entire premium in advance (employer and employee shares of the premium for employees and dependents);

3. All employees enrolled for coverage are required to participate in the Plan for a minimum 12-month period while eligibility for coverage exists unless the minimum enrollment requirement is waived by the Commission;

4. An employer who participates in the Employee Dental Plans is not eligible to request a premium delay of

30 or 60 days for payment of the premium charges pursuant to N.J.A.C. 17:9-5.2(a);

5. If an employer elects to participate in the Employee Dental Plans, the employee's share of the cost for the Plans may be determined by a formula different from that used to determine the employee's share of the cost of health coverage, provided that the employer's portion of the total premium cost for the Plans shall not be less than 50 percent. The employee may pay a share of the cost of dental coverage for the employee and for the employee's covered dependents as required by a collective negotiations agreement. The employer may establish by ordinance or resolution, rules for the employee's share of the cost for those employees not covered under a collective negotiations agreement;

6. An employer who does not participate in the SHBP or School Employees' Health Benefits Program is ineligible for participation in the Employee Dental Plans; and

7. An employer who elects to participate in the Employee Dental Plans must remain in the Plans for a minimum of 12 months before terminating coverage unless the employer terminates participation in the SHBP or School Employees' Health Benefits Program.

Amended by R.1995 d.3, effective January 3, 1995.
See: 26 N.J.R. 2202(a), 27 N.J.R. 128(a).
Repeal and New Rule, R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Section was "State Dental Expense Program comparable to State Health Benefits Program".
Amended by R.2005 d.63, effective February 22, 2005.
See: 36 N.J.R. 4692(a), 37 N.J.R. 628(a).
Rewrote the section.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In the introductory paragraph of (c), substituted "SHBP" for "State Health Benefits Program", and deleted "State Health Benefits" preceding "Commission"; deleted former (c)1, recodified former (c)2 through (c)8 as (c)1 through (c)7; in (c)3, deleted "State Health Benefits" preceding "Commission"; and in (c)6 and (c)7, substituted "SHBP or School Employees' Health Benefits Program" for "State Health Benefits Program".

17:9-9.2 Dental identification cards

Identification cards will be issued by the carrier upon the initial enrollment or change of coverage. Identification cards will be reissued periodically to assure the validity of coverage. All cards will be mailed directly to the employee's home.

Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.

17:9-9.3 Enrollment charges

Each eligible employee who enrolls for coverage shall be required to authorize the taking of deductions in order to pay for the employee's share of the cost of coverage for the employee and enrolled dependents.

Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.

17:9-9.4 Waiting period—Orthodontics under the Dental Expense Plan

Credit for qualified service with the same employer immediately preceding the employee's election to participate in the Plan or during any annual enrollment period shall count towards establishing the 10 months or more of continuous service required for orthodontics. Otherwise, all other benefits will be available and such participants will become eligible for orthodontics as soon as 10 months of continuous qualified service has been accumulated.

Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.
Recodified from N.J.A.C. 17:9-9.6 and amended by R.2005 d.63, effective February 22, 2005.
See: 36 N.J.R. 4692(a), 37 N.J.R. 628(a).
Inserted "with the same employer" following "service" in the first sentence, and deleted "State" preceding "service" throughout. Former N.J.A.C. 17:9-9.4, Enrollment forms, repealed.

17:9-9.5 Covered expenses

The Plans handbook supplements the master contracts and contains the specific provisions for services to be covered and those which are excluded.

Repeal and New Rule, R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Section was "Annual enrollment period".
Recodified from N.J.A.C. 17:9-9.7 and amended by R.2005 d.63, effective February 22, 2005.
See: 36 N.J.R. 4692(a), 37 N.J.R. 628(a).
Substituted "Plans" for "Plan" following "The". Former N.J.A.C. 17:9-9.5, Annual initial enrollment period, was repealed.

17:9-9.6 Deductible

Eligible charges incurred under a local employer's group dental coverage by an employee prior to the employer's enrollment in the Employee Dental Plans shall be considered toward satisfying the annual Employee Dental Plans deductible.

New Rule, R.2005 d.63, effective February 22, 2005.
See: 36 N.J.R. 4692(a), 37 N.J.R. 628(a).
Former N.J.A.C. 17:9-9.6, Waiting period—orthodontics under the dental expense plan, recodified to N.J.A.C. 17:9-9.4.

17:9-9.7 (Reserved)

Recodified to N.J.A.C. 17:9-9.5 by R.2005 d.63, effective February 22, 2005.
See: 36 N.J.R. 4692(a), 37 N.J.R. 628(a).
Section was "Covered expenses".

SUBCHAPTER 10. PROCUREMENT OF STATE HEALTH BENEFITS PROGRAM CONTRACTS

17:9-10.1 Purpose

This subchapter establishes the rules governing the procurement of contracts by the Commission for health benefit services and related actuarial and auditing services. The Commission, created by Section 3 (N.J.S.A. 52:14-17.26) of the New Jersey Health Benefits Program Act, P.L. 1961, c. 49 (N.J.S.A. 52:14-17.25 et seq.) as amended and supplemented, is responsible for negotiating and arranging for the purchase of such services.

Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Deleted "State Health Benefits" preceding the first occurrence of "Commission" and substituted "c. 49" for "c.49".

17:9-10.2 Source for public information

The public may obtain information concerning the Commission's procurement program and pending procurements by writing to the Director, Division of Pensions and Benefits, PO Box 295, Trenton, New Jersey 08625-0295.

17:9-10.3 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Auctioning" means, in a negotiated procurement, the practice of promoting price bidding between bidders by disclosing other bidders' prices and/or holding repeated rounds of best and final offers.

"Best and final offer" means, in a procurement permitting negotiations, the bid proposal resubmitted by the bidder at the end of negotiations.

"Bidder" refers to the vendor submitting a bid proposal in response to a Request for Proposal.

"Bid proposal" refers to the bidder's offer to furnish services in response to a Request for Proposal.

"Bid list" refers to a list of vendors maintained by the Division of Pensions and Benefits who have expressed an interest in submitting bid proposals in response to future Requests for Proposals.

"Bypass" refers to a contract award to other than the lowest priced responsive bidder. A bypass occurs when the Commission determines that the bid proposal that is most advantageous to the State is not the lowest priced, responsive bid proposal.

"Commission" means the State Health Benefits Commission.

"Competitive range" refers to those responsive bid proposals determined to have a reasonable possibility of being selected for contract award following evaluation.

"Contract" is a written agreement between the Commission and the contractor setting forth obligations, including: performance of work, furnishing of labor and materials, and the basis of payment.

"Contract documentation" refers to paperwork verifying that the selected bidder has satisfied the conditions precedent to contract execution. Examples include: evidence of compliance with State Affirmative Action requirements, N.J.S.A. 10:5-31 et seq.; evidence of compliance with the MacBride principles of nondiscrimination in employment, N.J.S.A. 52:34-12.2; evidence of business registration with the Division of Revenue; required certificates of insurance; and required performance security.

"Contract execution" refers to the signing of the contract by the selected bidder and the Director following Commission approval and the selected bidder's submission of contract documentation.

"Contractor" refers to the individual, partnership, firm, corporation, company, or joint venture contracting with the Commission for the performance of the work that is the subject of the Request for Proposal.

"Day" means business day, not including Saturday, Sunday or a State legal holiday.

"Director" refers to the Director of the Division of Pensions and Benefits.

"Division" refers to the Division of Pensions and Benefits.

"Evaluation committee" refers to a formal selection committee established by the Director to evaluate bid proposals received in response to a Request for Proposal on the basis of price and other factors, as set forth in the Request for Proposal.

"Evaluation criteria" refers to factors set forth within the Request for Proposal, usually weighted, specifying the basis for the technical evaluation of bid proposals received.

"Filed" means received by the Director.

"Negotiation" refers to discussions conducted with responsive bidders whose bid proposals are determined to be within the competitive range.

"Notice of Intent to Award" refers to the Director's correspondence to all bidders advising of the Commission's contract award decision.

"Performance security" means a guarantee, in the form of a deposit or a bond, submitted by the selected bidder subsequent to the Notice of Intent to Award and prior to contract execution, that the selected bidder will complete the contract

and that the Commission will be protected from loss in the event the selected bidder fails to complete the contract.

"Protest" refers to a timely challenge of a Request for Proposal requirement or to the Commission's contract award decision.

"Request for Proposal" or "RFP" refers to all documents, whether attached or incorporated by reference, used for soliciting bid proposals for the services specified therein.

"Responsible bidder" refers to a bidder who has demonstrated integrity and the capability to successfully provide the services being procured.

"Responsive bidder" refers to a bidder whose bid proposal conforms to all material requirements of the RFP.

"State" refers to the State of New Jersey.

"Technical leveling" means, in a negotiated procurement, helping a bidder bring its bid proposal up to the level of other bid proposals through successive rounds of negotiations by pointing out the weaknesses that remain in the bid proposal due to the bidder's lack of diligence, competence or inventiveness.

"Technical transfusion" means, in a negotiated procurement, the disclosure of the contents of one bidder's bid proposal to another bidder to help the other bidder improve its bid proposal.

17:9-10.4 Procurement methodology

(a) All purchases shall be through formal, advertised sealed bidding, except as provided in this subchapter.

(b) The Director shall prepare the RFP for formal, advertised, sealed bidding at the request of the Commission.

(c) The Director shall structure the RFP for formal, advertised, sealed bidding to provide for a single contract award to a single bidder, unless contract awards to two or more bidders are permitted as hereinafter provided in this subchapter.

(d) The Director may structure an RFP for formal, advertised, sealed bidding to include multiple price lines encompassing more than one service or group of services, with a separate contract award for each price line.

(e) The Director may structure an RFP for formal, advertised, sealed bidding to be awarded to two or more bidders on the basis of one or more of the following criteria:

1. The anticipated demand for health care services by employees of the State and their dependents and employees and dependents of participating local government employers and the ability of potential bidders to meet the anticipated demand;

2. The need for comprehensive in-State and out-of-State health care networks and/or the need for diversity in health care plans offered; and/or

3. The need for cost efficient, timely delivery of auditing and actuarial services.

(f) The Director may structure the RFP for formal, advertised, sealed bidding to provide for negotiation.

17:9–10.5 Notice of formal, advertised, sealed bidding opportunities

(a) A notice of bid opportunity shall be advertised in newspapers or other such media as allowed by law and selected by the Commission, as will give best notice thereof to bidders. Advertisements shall be placed a minimum of 30 calendar days in advance of bid opening.

(b) Notice of bid opportunity and the RFP shall be published on the Division's website a minimum of 30 calendar days in advance of bid opening.

(c) If an amendment to a published RFP is necessary, notice of the amendment and the amendment shall be published on the Division's website a minimum of five working days in advance of bid opening.

(d) The Division shall maintain a list of vendors having expressed an interest in bidding in response to a particular contract initiative. Vendors on the list shall be provided e-mail notice of the publication on the Division's website of any RFP that they have expressed an interest in receiving and e-mail notice of the publication on the Division's website of any subsequent amendment to such RFP. However, the mere placement of a vendor's name on the bid list does not create an absolute entitlement to notice. It is the vendor's responsibility to exercise due diligence in reviewing legal notices and the Division's website to ensure its participation in bidding opportunities.

17:9–10.6 Requirements for formal, advertised, sealed bidding

(a) In order to be eligible for consideration for award of contract, the bidder's bid proposal must:

1. Be submitted on or before the opening date and time and at the place specified in the RFP;

2. Be signed by an individual with the authority to legally bind the bidder;

3. Include all required completed forms;

4. Be accompanied by bid security when required;

5. Include pricing information;

6. Be preceded by the bidder's attendance at any pre-bid conference for which attendance is mandatory. However, the Director reserves the right to allow a vendor to meet a pre-bid conference attendance requirement by listening to a tape recording of the pre-bid conference. This right may be exercised by the Director upon a vendor's verifiable demonstration of extenuating circumstances, which prevented attendance, or for other factors deemed, by the Director, to be in the State's best interest;

7. Contain initials of an individual with the authority to legally bind the bidder adjacent to any price alterations. If a unit price in a bid proposal has been altered or appears to be an alteration, the initials must appear adjacent to the alteration. Examples of alterations include, but are not limited to, cross outs, erasures, white-outs, writeovers, and strikeovers, with re-entered prices;

8. Be prepared in ink or typewritten. If information essential to a bid evaluation, including, but not limited to, price, terms and production description, is submitted in pencil, the bid proposal shall be rejected unless that same essential information appears elsewhere in the bid proposal, either typewritten or printed, and provided that the information is entirely consistent with the information submitted in pencil and does not invite any other interpretation;

9. Include a completed Ownership Disclosure Form or have a completed Ownership Disclosure Form on file with the State, in conformance with N.J.S.A. 52:25–24.2; and

10. Be sealed. Telephone, telefacsimile or electronic bid proposals will not be accepted for publicly advertised bid solicitations requiring the submittal of sealed bids.

(b) Any bid proposal failing to comply with the provisions of (a) above shall be subject to automatic rejection.

(c) The Commission may reject all bid proposals received when in the public interest to do so.

17:9–10.7 Performance security

(a) Based upon the Director's review of market conditions and evaluation of potential risk to the Commission and the State, the RFP may require that performance security be posted by the selected bidder prior to contract execution.

(b) Performance security, in the amount set forth in the RFP, shall consist of a certified or cashier's check drawn to

the order of "New Jersey State Health Benefits Commission," a performance bond issued by an insurance or security company authorized to do business in the State of New Jersey, or an irrevocable letter of credit issued by a Federally insured financial institution and naming the "New Jersey State Health Benefits Commission" as beneficiary.

17:9–10.8 Bid opening

(a) Bid proposals must be received prior to or at the time and place designated in the RFP for bid opening. Late bid proposals will be rejected. The Director may extend the time for bid opening when a vendor notifies the Director of the vendor's intent to bid but, due to an emergency, timely delivery of the bid proposal is not possible. The bidder making such request must do so prior to the time of the scheduled bid opening. If the Director determines that a delayed bid opening is in the State's best interest, the Director shall designate a revised bid opening time.

(b) For RFPs not having a negotiation component, the bidder's name, address and bid pricing will be read at bid opening. Bid proposals will be made available for public review thereafter upon request and as scheduled by the Director.

(c) For RFPs having a negotiation component, only the names and addresses of the bidders will be read at bid opening. Bid proposals shall be made available for public review, upon request and scheduling by the Director, after issuance of the Notice of Intent to Award by the Director.

(d) Each bid proposal and, if applicable, each best and final offer will be available for public inspection in accord with the Open Public Records Act, N.J.S.A. 47:1A–1 et seq. Within its bid proposal, the bidder must identify any data or materials it asserts are exempt from public inspection under the Act and explain the basis for such assertion. The assertion that the entire bid proposal or prices bid are exempt from public inspection under the Act is not acceptable and will result in the rejection of the bid proposal.

17:9–10.9 Bid errors

(a) Prior to bid opening, a bidder discovering an error in its bid proposal may withdraw the bid proposal by notifying the Director in writing. The bidder may submit a revised bid proposal provided it is received prior to bid opening.

(b) After bid opening, a bidder discovering an error in its bid proposal must make written application to the Director for authorization to withdraw its bid proposal. The Director shall consider the bidder's good faith in making the request, as evidenced by whether the mistake relates to a material term of the RFP; whether the mistake occurred notwithstanding the bidder's exercise of reasonable care; and whether the State would be significantly prejudiced by granting the request.

17:9–10.10 Evaluation of bid proposals

(a) An evaluation committee shall be appointed by the Director prior to bid opening to evaluate bid proposals received.

(b) Prior to bid opening, the evaluation committee shall establish weights for the evaluation criteria set forth in the RFP. Weights established will be date-stamped prior to bid opening. For RFPs having a negotiation component, weights established will not be made public until after the Director's issuance of the Notice of Intent to Award. For RFPs not having a negotiation component, weights established will be made public at bid opening.

(c) Bid proposals shall be reviewed by the evaluation committee to ensure that each meets the requirements for bidding set forth at N.J.A.C. 17:9–10.6 and is responsive to the material requirements of the RFP. A bid proposal not meeting the requirements for bidding set forth at N.J.A.C. 17:9–10.6 and/or not responsive to the material requirements of the RFP shall receive no further consideration.

(d) The evaluation committee may request a bidder to clarify its bid proposal. The process of clarification, however, is not an opportunity for a bidder to revise or modify its bid proposal.

(e) Responsive bid proposals in the competitive range will be evaluated by the evaluation committee on the basis of price and the evaluation criteria set forth in the RFP.

(f) The evaluation committee may recommend bypassing a lower priced responsive bid proposal on the basis of:

1. The superiority of the higher priced responsive bid proposal;

2. Issues relating to the integrity of the bidder submitting the lower priced responsive bid proposal; and/or

3. The documented poor performance of the bidder submitting the lower priced responsive bid proposal.

(g) The evaluation committee shall submit a contract award recommendation, based on price and the evaluation criteria in the RFP, to the Director.

(h) The Director shall review the evaluation committee's contract award recommendation and any other documentation the Director deems relevant. The Director shall submit the evaluation committee's contract award recommendation, and any comments the Director may have relating thereto, to the Commission for consideration.

(i) The Commission shall review the evaluation committee's contract award recommendation, the Director's comments, if any, and any other documentation the Commission deems relevant. The Commission shall make a decision to award or not award the contract on the basis of price and the evaluation criteria set forth in the RFP.

(j) In the event the decision of the Commission is to award a contract, the Director shall issue a Notice of Intent to Award to the selected bidder. The Director shall provide a copy of the Notice of Intent to Award to all bidders. The Notice of Intent to Award shall identify all outstanding contract documentation and the time being afforded the selected bidder to submit all outstanding contract documentation to the Director. The selected bidder's failure to provide all outstanding contract documentation to the Director within the time afforded shall constitute cause for the Commission to rescind the Notice of Intent to Award. In such instance the Commission may instruct the Director to reissue the Notice of Intent to Award to another bidder.

(k) In the event the decision of the Commission is not to award a contract, the Director shall provide written notice to all bidders.

17:9–10.11 Evaluation of bid proposals permitting negotiation

(a) In addition to the requirements for the evaluation of bid proposals set forth at N.J.A.C. 17:9–10.10, the following requirements shall apply to negotiated procurements:

1. The evaluation committee's option to negotiate shall be expressly set forth in the RFP;

2. Mandatory requirements of the RFP are not negotiable;

3. Negotiations are limited to responsive bidders in the competitive range;

4. The evaluation committee shall notify each responsive bidder in the competitive range in general terms of the deficiencies in its bid proposal;

5. The evaluation committee may hold more rounds of negotiations with one responsive bidder in the competitive range than with another;

6. Negotiations shall be structured to safeguard information and ensure that all responsive bidders in the competitive range are treated fairly. Technical transfusion, technical leveling and auctioning are precluded;

7. Following completion of negotiations, the evaluation committee shall provide written notice to all responsive bidders in the competitive range that negotiations have concluded. Such notice shall advise all responsive bidders in the competitive range of the time and place for submission of best and final offers;

8. Each responsive bidder in the competitive range is limited to one best and final offer. The best and final offer can modify any aspect of the bid proposal, provided mandatory requirements of the RFP are satisfied; and

9. Best and final offers are not negotiable. Evaluation of best and final offers by the evaluation committee shall be on the basis of price and the evaluation criteria set forth in the RFP.

17:9–10.12 Preference laws; out-of-State bidders

(a) Pursuant to N.J.S.A. 52:32–1.4, when another state has residential preference laws, rules or regulations that disadvantage a bidder not having its principal place of business in that state, the Commission may reciprocally apply such disadvantage to an out-of-State bidder having its principal place of business in such state.

(b) The Commission may waive the reciprocal application of another state's residential preference law, rules or regulations when such waiver would be in the best interest of the Commission and the State.

17:9–10.13 Protest

A protest of either an RFP requirement or a contract award decision of the Commission is not a contested case subject to the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq.

17:9–10.14 Protest of an RFP requirement

(a) A vendor objecting to an RFP requirement should submit a written protest to the Director no later than 15 days prior to bid opening to permit the Director adequate time to review the merits of such protest and issue a decision prior to bid opening.

(b) Such protest shall include all arguments, materials or other documentation supporting the vendor's objection to the RFP requirement.

(c) A protest of an RFP requirement will not be considered after bid opening.

(d) In the event a protest results in an amendment to an RFP requirement, such amendment shall be published in accordance with N.J.A.C. 17:9–10.5. In such event, the Director may reschedule bid opening to ensure the receipt of responsive bid proposals.

(e) In the event a protest results in an amendment to an RFP requirement 15 or fewer days prior to the originally scheduled bid opening, any protest of an RFP requirement thereafter shall be limited to the RFP amendment.

(f) Appeal from the Director's decision shall be to the Commission. Such appeal must be filed with the Director within five days of receipt of the Director's decision. If necessary, the Director shall reschedule bid opening to permit time for the Commission's consideration of an appeal and issuance of a final agency decision.

17:9–10.15 Protest of a Commission contract award decision

(a) Protest of a Commission contract award decision must be filed with the Director within 10 days of the bidder's receipt of the Notice of Intent to Award.

(b) The protest must set forth in detail the specific grounds for challenging the Commission's contract award decision. The protest must include all arguments, materials and/or other documentation that may support the protester's position that the Commission's contract award decision was in error.

(c) The Director shall afford the selected bidder the opportunity to comment on the merits of the protest. Upon receipt of the selected bidder's comments, if any, the Director shall review the written protest, the selected bidder's comments, if any, the RFP, the bid proposal(s) in question, pertinent administrative rules, statutes and case law and any related documentation the Director deems appropriate. Thereafter, the Director shall issue a written decision.

(d) Appeal from the Director's decision shall be to the Commission. Such appeal must be filed with the Director within five days of the protestor's and/or selected bidder's receipt of the Director's decision.

17:9–10.16 Appeal to Commission

(a) In the event of an appeal to the Commission from the Director's decision relating to either a protest of an RFP requirement or a protest of a Commission contract award decision:

1. The Commission shall have sole discretion to determine if an oral presentation by the protester is necessary to reach an informed final agency decision on the merits of the protest. In the event the Commission determines that it can reach an informed final agency decision upon a review of the written record, such review shall constitute the informal agency hearing;

2. Oral presentations are fact-finding for the benefit of the Commission. The Commission has the discretion to limit attendance at an oral presentation to the protestor and, in the event the protest relates to a contract award decision, the selected bidder; and

3. The Commission may appoint a hearing officer. In such case, the hearing officer's report shall be advisory in nature. All parties shall receive a copy of the hearing officer's report and shall have 10 days to provide written comments or exceptions thereto to the Commission. Subsequent to the 10–day period for comments or exceptions, the Commission shall render its final agency decision.

17:9–10.17 Discovery procedures

The Director or the Commission is entitled to request, receive and review copies of any and all records and documents deemed relevant to the issues and arguments set forth in a protest. Upon receipt of such request, the protesting bidder or, in the event of a protest of a Commission contract award decision, the selected bidder shall promptly provide the requested records and documents free of charge in the time, place and manner specified. Failure to comply may, at the discretion of the Director or the Commission, constitute sufficient basis to resolve the protest against the noncomplying party. The Director or the Commission may also consider relevant information requested and received from other parties as deemed appropriate.

17:9–10.18 Contract execution

In the event a challenge to a Commission contract award decision is not filed within 10 days of the Director's issuance of the Notice of Intent to Award or, if filed, is resolved in favor of the selected bidder, and the selected bidder has submitted all required contract documentation to the Director, the Director, as Secretary of the Commission, will execute the contract with the selected bidder.

17:9–10.19 Exceptions to formal, advertised, sealed bidding

(a) The Commission may contract without formal, advertised, sealed bidding in one or more of the following situations:

1. Services to be performed are of a technical and professional nature;

2. Bid prices after advertising are not reasonable or independent, provided that each responsive bidder is provided the opportunity to submit revised prices;

3. The purchase is from the Federal or any State government or political subdivision thereof;

4. Public exigency, that is, life, health and/or other emergencies, requiring the immediate delivery of the services; and/or

5. Only one source of supply is available.

(b) Prior to finalization of any contract pursuant to (a) above, the proposed contractor shall provide the Director with evidence of compliance with Ownership Disclosure requirements, N.J.S.A. 52:25–24.2; evidence of compliance with State Affirmative Action requirements, N.J.S.A. 10:5–31 et seq.; evidence of compliance with MacBride principles of nondiscrimination in employment, N.J.S.A. 52:34–12.2; evidence of business registration with the Division of Revenue; required certificates of insurance; and required performance security.

(c) Prior to recommending a contract award to the Commission for approval pursuant to (a)1 and/or 2 above, the Director shall seek competition from a minimum of three firms. Proposals received shall be evaluated on the basis of price and other factors.

17:9–10.20 Contract rescission

(a) The Commission may, in the following circumstances, rescind a contract and obtain services from another vendor, charging the defaulting contractor the difference in price, if any, and administrative costs incurred:

1. Refusal of a contractor to bring services into compliance with the contract in the time or manner specified by the Director or the Commission; and/or

2. Refusal of a contractor to answer inquiries from the Division, the Director or the Commission within a reasonable period following receipt thereof.

17:9-10.21 Mutual cancellation of contract

Upon receipt of a written request from a contractor, the Commission may, under extraordinary circumstances, agree to a mutual cancellation of the contract. The Commission may require the contractor pay the difference in price, if any, associated with securing the services from another source and any administrative expenses associated therewith.

17:9-10.22 Waiver of time periods

The Director or the Commission may, in instances where public exigency exists or where there is potential for substantial cost benefit or other advantage, modify or amend the time periods set forth in this subchapter. In such an instance, the Director or the Commission shall give adequate notice to the parties involved.

17:9-10.23 Authority to contract

Nothing in the rules set forth in this subchapter shall preclude the Commission from requesting the Division of Purchase and Property to contract on the Commission's behalf for medical benefit services and related actuarial and auditing services. In such instance, the procurement rules, policies and procedures of the Division of Purchase and Property, N.J.A.C. 17:12, shall govern.

SUBCHAPTER 11. PART-TIME EMPLOYEES GROUP

17:9-11.1 Establishment of Part-time Employees Group

(a) The SHBP Part-Time Employees Group was established under the provisions of P.L. 2003, c. 172 (N.J.S.A. 52:14-17.33a).

(b) Enrollment for coverage is voluntary. A separate election will be required for enrollment, change in or a voluntary termination of coverage in the Part-time Employees Group. If an employee does not elect coverage within 60 days of eligibility for participation in the Part-time Employees Group, the employee may only enroll during an open-enrollment period.

(c) The laws and rules governing the SHBP, except as modified in this subchapter, are construed to apply to part-time employees or faculty members and their dependents to the extent possible.

(d) Except under the provisions of the Federal COBRA law, coverage is not continued in the event of death, or other termination of the group coverage.

(e) Duplicate coverage is not permitted; an individual may be covered only once. An individual eligible as both a subscriber and as the dependent of someone else can be enrolled as an employee or as a dependent but not as both an employee and a dependent.

(f) Coverage may be continued during an approved leave of absence without pay of not more than nine months provided the employee pays the monthly premium.

(g) Eligible dependents may be added during the open enrollment or if a qualifying event occurs as defined by N.J.A.C. 17:9-2.4.

(h) Where the otherwise eligible employee elects a volunteer furlough or a voluntary furlough extension, as authorized by N.J.S.A. 11A:6-1.1, coverage shall continue with the employee paying the costs as if the member were an active employee, provided that the employee remits, in advance, the monthly amount required for the employee's coverage.

Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In (a) and (c), substituted "SHBP" for "State Health Benefits Program"; in (a), substituted "c. 172" for "c.172"; in (c), substituted "rules" for "regulations"; and in (d), deleted "Consolidated Omnibus Budget Reconciliation Act of 1985, 29 U.S.C. §§1161-1168 (" preceding and a closing parenthesis following "COBRA", and deleted the last sentence.

17:9-11.2 Eligible part-time employees

Part-time employees of the State, including employees of the State colleges and universities, New Jersey Building Authority, New Jersey State Library, Palisades Interstate Parkway Commission, and the Commerce and Economic Growth Commission participating in the SHBP, are eligible to enroll if they are members of the State-administered retirement system.

Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Deleted ", as well as part-time faculty at county colleges" following "Growth Commission".

17:9-11.3 Coverage available

(a) The State Managed Care Plan is NJ DIRECT15.

(b) Pursuant to P.L. 2003, c. 172 (N.J.S.A. 52:14-17.33a), members of the Part-time Employees Group shall be eligible for coverage in NJ DIRECT15. Members shall also be eligible for coverage under the State Employee Prescription Drug Plan. There shall be no prescription drug coverage under NJ DIRECT15.

(c) Eligible employees may waive enrollment in the State Employee Prescription Drug Plan, but in no case shall they be allowed to enroll in the State Employee Prescription Drug Plan without also being enrolled in NJ DIRECT15.

(d) There is no eligibility for dental or vision or any other benefit created by P.L. 2003, c. 172.

Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Substituted "DIRECT15" for "PLUS" throughout; and in (b) and (d), substituted "c. 172" for "c.172".

17:9-11.4 Payment of coverage

The employee will be billed directly for the cost of premiums plus administrative fees.

17:9-11.5 Cost of coverage

The Commission may adopt separate rates for the Part-time Employees Group reflecting the actual cost of the benefit plus administrative costs.

Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Deleted "State Health Benefits" preceding "Commission".

17:9-11.6 Effective date of coverage

(a) Coverage for all members of the Part-time Employees Group shall be on a monthly basis.

(b) The coverage for members eligible to enroll in the Part-time Employees Group shall be effective on the first of the month following the completion of two months of continuous service after enrollment in a State-administered retirement system, or two months after the effective date of P.L. 2003, c.172 (January 1, 2004). This is the normal waiting period prescribed for new enrollees pursuant to N.J.S.A. 52:14-26. Billing for coverage shall begin approximately one month prior to the effective date.

(c) An employee hired under a 10-month contract whose enrollment in a State-administered retirement system becomes effective on September 1 may establish coverage in the Part-time Employees Group as of that date.

17:9-11.7 Effect of full-time employment on participation in the Part-time Employees Group

A member of the Part-time Employees Group who changes from part-time to full-time status cannot be enrolled for full-time employee coverage until the employee has established eligibility for coverage by serving the normal waiting period prescribed for new enrollees. In no event will the waiting period for full-time coverage include any part-time service rendered by the employee.

Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Substituted "full-time employee" for "employer-paid".

17:9-11.8 Termination of coverage due to nonpayment of premiums

(a) Cessation of coverage in the Part-time Employees Group shall be deemed to occur on the last day of eligibility for the coverage period for which charges have been paid.

(b) If a member of the Part-time Employees Group does not remit payment by the end of the month in which payment is due and owing, the SHBP shall notify the member of the overdue amount plus the current amount due on the next billing statement; such notice shall also advise the member that the right to continue coverage will be terminated if payment in full is not remitted within 30 days. If no payment is made by the due date, the SHBP shall terminate the coverage effective on the last day of the month for which premiums were paid.

(c) Termination for nonpayment of premiums is not a COBRA event. An active employee terminated for nonpayment of premiums would not be able to re-enroll in the Part-time Employees Group until the next regular open enrollment.

17:9-11.9 Termination of coverage due to termination of employment with an eligible employer

The eligibility for coverage for members of the Part-time Employees Group ends at the end of the month in which termination from an eligible employer occurs. The employer must notify the Division of Pensions and Benefits of the termination and issue the employee a COBRA notice.

17:9-11.10 Coverage in retirement

(a) Participation in the Part-time Employees Group pursuant to this section shall not qualify the employee or faculty member for employer-paid or State-paid health care benefits in retirement. Upon retirement, such employees or faculty members who were enrolled in NJ DIRECT15 immediately prior to retirement shall be eligible to continue NJ DIRECT15 coverage as a retiree at their own expense. Prescription drug benefits shall be provided through the Retiree Prescription Drug Card Plan (N.J.A.C. 17:9-6.10).

(b) Whenever possible, the cost of retiree coverage will be deducted directly from the retirement allowance. Where the available retirement allowance is less than the charge for coverage, no amount will be deducted to pay for the cost of the coverage; instead, the retiree will be permitted to continue coverage if the retiree pays for the full cost of coverage in advance on a monthly basis.

(c) An eligible surviving spouse or eligible partner will be offered the opportunity to continue participation in NJ DIRECT15 subsequent to the death of the retiree. Coverage will be limited to only those dependents covered at the time of the retiree's death. The surviving spouse or eligible partner must pay the full costs.

Amended by R.2005 d.187, effective June 20, 2005.
See: 37 N.J.R. 397(a), 37 N.J.R. 2212(b).
In (c) inserted "or eligible domestic partner" following "spouse" throughout.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In (a), substituted "DIRECT15" for the first and second occurrences of "PLUS", and deleted "under NJ PLUS" following the second occurrence of "benefits"; in (b), deleted "or pension checks" following the first occurrence of "allowance" and "or pension check" following the second occurrence of "allowance"; and in (c), deleted "domestic" preceding "partner" twice, and substituted "DIRECT15" for "PLUS".

SUBCHAPTER 12. RETIREE DENTAL EXPENSE PLAN

17:9-12.1 Retiree Dental Expense Plan

(a) The Retiree Dental Expense Plan (Plan) was established under the provisions of N.J.S.A. 52:14-17.29(F) and became effective as of January 1, 2005. The Plan is available to retirees eligible for participation in the SHBP and School Employees' Health Benefit Program and their eligible dependents. New retirees may enroll by completing an application at the time of retirement. The Plan is a Dental Expense Plan, which is a traditional indemnity-type plan, which allows the employee to select any licensed dentist for dental care.

(b) Participation in the Plan is voluntary. A separate election will be required for enrollment and for a change in, or a voluntary termination of, coverage in the Plan.

(c) The rules are the same as those of the SHBP as administered by the Commission in accordance with the provisions of N.J.S.A. 52:14-17.25 et seq., with the following exceptions:

1. Coverage is not continued in the event of termination from the SHBP. There is no eligibility to continue retired dental coverage under the Federal COBRA law;

2. Duplicate coverage is not permitted; an individual may be covered as a retiree or as an employee or dependent but not as both a retiree and a dependent or retiree or employee. Dependent children may only be covered by one parent; and

3. Retirees are offered one opportunity to elect enrollment in the Plan. If a retiree declines coverage when first eligible or elects to terminate Plan coverage, the retiree and the retiree's dependents are ineligible to enroll in the Plan at a later date except as permitted under the provisions of N.J.A.C. 17:9-6.

Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Section was "The Retiree Dental Expense Plan". In (a), substituted "SHBP and School Employees' Health Benefit Program" for "State Health Benefits Program", and inserted a comma following the last occurrence of "Plan" and "plan"; in the introductory paragraph of (c) and in (c)1, substituted "SHBP" for "State Health Benefits Program"; in the introductory paragraph of (c), deleted "State Health Benefits" preceding "Commission", and inserted a comma following "et seq."; in (c)1, deleted "the Consolidated Omnibus Budget Reconciliation Act of 1985, 29 U.S.C. §§ 1161-1168 (" preceding and a closing parenthesis following "COBRA"; deleted former (c)2; and recodified former (c)3 and (c)4 as (c)2 and (c)3.

17:9-12.2 Plan premiums

(a) The State will not make any contributions for the cost of dental coverage.

(b) Local participating employers through collective negotiation agreements may pay nothing, all or a portion of the premium cost of the Plan for eligible retirees pursuant to the provisions of N.J.A.C. 17:9-5.4(e).

(c) Premium payments are deducted directly from a retiree's monthly retirement allowance. If the retirement allowance is not sufficient to cover the full premium, the retiree will be billed monthly for the coverage.

17:9-12.3 Plan progressive coinsurance design

(a) The Plan has three progressive coinsurance tiers. The highest tier provides a greater percentage of reimbursement for reasonable and customary charges than the lower two tiers. Each year a retiree remains a member of the Plan, the coinsurance tier rises until the retiree reaches the highest tier.

1. A retiree who was enrolled in a group dental plan immediately proceeding eligibility for coverage in the Plan, and who was covered under a group dental plan for at least one year within 60 days of joining this Plan, is eligible for enrollment at the highest tier of reimbursement.

2. A retiree who was not enrolled in a group dental plan for at least one year immediately proceeding eligibility for coverage in the Plan shall be enrolled in the lowest tier of reimbursement.

3. A dependent is enrolled at the same tier of reimbursement as the retiree.

(b) The maximum annual benefit amount is the same for each tier.

17:9-12.4 Covered expenses

The Plan handbook supplements the master contracts and contains the specific provisions for services to be covered and those which are excluded. Orthodontic services are not covered under the Plan.

17:9-12.5 Deductible

Charges incurred by a retiree prior to enrollment in the Plan shall not be considered toward satisfying the Plan deductible.

SUBCHAPTER 13. CHAPTER 375 DEPENDENTS

17:9-13.1 Eligibility criteria

(a) In order for a dependent to qualify for and remain eligible for SHBP coverage after age 23 as a Chapter 375 dependent, the dependent must be a covered person's child by blood or law who:

1. Is 30 years of age or younger;

2. Is unmarried;

3. Has no dependent of his or her own;

4. Is a New Jersey resident or enrolled as a full-time student at an accredited public or private institution of higher education; and

5. Is not actually provided coverage as a named subscriber, insured, enrollee, or covered person under any other group or individual health benefits plan, group health plan, church plan, or health benefits plan, or entitled to benefits under either Title XVIII of the Social Security Act, Pub.L. 89-97 (42 U.S.C. §§1395 et seq.).

Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In the introductory paragraph of (a), substituted "SHBP" for "State Health Benefits Program"; and in (a)1, deleted "less than" preceding "30", and inserted "or younger".

17:9-13.2 Enrollment

(a) Enrollment of a Chapter 375 eligible dependent is voluntary. A separate election will be required for enrollment, change in or a voluntary termination of coverage for a Chapter 375 eligible dependent. If an employee or retiree (subscriber) does not elect coverage for a Chapter 375 eligible dependent by December 31, 2007, the subscriber may thereafter enroll the dependent as follows:

1. Submission of an enrollment application and certificate of creditable coverage to the Division no later than 30 days after the dependent meets all eligibility criteria under N.J.A.C. 17:9-13.1. Coverage will be effective the first coverage period of the month, 60 days after the dependent meets all eligibility criteria.

2. In the event a subscriber does not submit an enrollment application to the Division within 30 days after the dependent meets all eligibility criteria under N.J.A.C. 17:9-13.1, the subscriber can only enroll the dependent during the annual October open enrollment period. If the dependent meets all eligibility criteria, coverage will be effective the first coverage period in January, following the open enrollment period.

(b) A subscriber who elects to enroll a dependent as a Chapter 375 dependent must report the dependent's qualifying status on the enrollment form and such signed enrollment form shall constitute the subscriber's certification that such dependent is the subscriber's child by blood or law and that such dependent satisfies, or will satisfy at the time of coverage, all eligibility criteria under N.J.A.C. 17:9-13.1. The subscriber is under a continuing obligation to immediately report any change in the dependent's qualifying status to the Division.

Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In (a)1, inserted "and certificate of creditable coverage".

17:9-13.3 Coverage available

(a) An enrolled Chapter 375 dependent shall be provided coverage in the same medical plan in which the subscriber is enrolled. In the event the subscriber participates in a SHBP prescription drug plan, the Chapter 375 dependent shall also qualify for participation in the same SHBP prescription drug plan.

(b) A Chapter 375 dependent is not eligible to receive dental or vision benefits.

Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In (a), deleted "State Health Benefits Program (" preceding and a closing parenthesis following "SHBP".

17:9-13.4 Premium rates and payment for coverage

The Commission shall determine premium rates for enrolled Chapter 375 dependents as provided by P.L. 2008, c. 38. The subscriber or dependent is responsible for the cost of the SHBP coverage for each enrolled Chapter 375 dependent.

Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
Rewrote the section.

17:9-13.5 Termination of coverage

(a) SHBP coverage for a Chapter 375 dependent shall terminate in the event:

1. The Chapter 375 dependent no longer meets all of the criteria for eligibility at N.J.A.C. 17:9-13.1 except that the dependent shall be eligible for coverage until his or her 31st birthday;

2. The employee's or retiree's death or other termination of the employee's or retiree's coverage;

3. The Chapter 375 dependent enters the Armed Forces;

4. The employee, retiree or dependent fails to make required premium payments for the Chapter 375 dependent; or

5. The Chapter 375 dependent dies.

(b) For any event described in (a)1 through 3 above, SHBP coverage for the Chapter 375 dependent shall terminate on the first day of the month following the event. With respect to (a)4 above, SHBP coverage for the Chapter 375 dependent shall terminate on the last day of the month for which a premium payment was made. With respect to (a)5 above, SHBP coverage shall terminate immediately following the Chapter 375 dependent's death.

(c) Termination of SHBP coverage for a Chapter 375 dependent is not a qualifying event for the continuation of SHBP coverage under the Consolidated Omnibus Budget Reconciliation Act, P.L. 99-272 (COBRA).

Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In the introductory paragraph of (a), deleted "State Health Benefits Program (" preceding and a closing parenthesis following "SHBP"; in (a)1, inserted "except that the dependent shall be eligible for coverage until his or her 31st birthday"; and in (a)4, substituted a comma for "or" preceding "retiree", and inserted "or dependent".

17:9-13.6 Notice of Termination of coverage for nonpayment of premiums

(a) If a subscriber or dependent fails to make a required premium payment for a Chapter 375 dependent by the end of the month in which premium payment is due, the Division shall notify the subscriber or dependent of the overdue amount on the next billing statement. Such notice shall advise the subscriber or dependent that the Chapter 375 dependent's right to continue coverage will be terminated if payment of the overdue premium payment and the current premium payment due is not remitted to the Division within 30 days. If payment is not remitted within 30 days, the Division shall terminate the Chapter 375 dependent's coverage effective the last day of the month for which premiums were paid.

(b) A Chapter 375 dependent terminated for nonpayment of premiums is not eligible to re-enroll as a Chapter 375 dependent until the next regular open enrollment, provided the dependent still meets all Chapter 375 dependent eligibility criteria.

Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).
In (a), inserted "or dependent" three times.