

(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 State Health Benefits Program (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 State Health Benefits Program 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 negotiations 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.

(e) The surviving spouse 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 State Health Benefits Program. If the deceased retiree would have been eligible for such coverage but was not enrolled due to active health benefit coverage as an employee, the surviving spouse may enroll in the SHBP, on a prospective basis, within six months after the retiree's death. The surviving spouse 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.

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).

17:9-6.10 Retiree prescription drug card 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 card plan” or “card 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.

“Provider” means an insurance company, hospital, medical, or health service corporation, or health maintenance organization under agreement or contract with the Commission to administer the card plan.

“Retail pharmacy” means a pharmacy, drug store or other retail establishment in this State at which prescription drug products 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 card 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) As a pilot program for five years (from March 20, 2000 to March 20, 2005), 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 NJ PLUS shall be provided under the prescription drug card plan. Payment for prescription drug expenses or the co-payments required under the card plan shall not be made under the major medical portion of the Traditional Plan or NJ PLUS. 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 card plan.

(c) Eligibility of prescription drug expenses for coverage under the card plan shall be determined on the same basis as reasonable and necessary medical expenses under the major medical portion of the Traditional Plan and NJ PLUS.

(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 card 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 card 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 card 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 card 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 card 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 card 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 card plan shall comply with N.J.A.C. 11:4-37.3(c)1 through 4, 6 and 7 in administration of the card 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.

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).

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) Cessation of SHBP coverage for a member who is awaiting approval of a retirement benefit shall not occur if the retiring member agrees, in writing, to the deduction of any retroactive SHBP premiums owed by the subscriber from the retirement benefit when approved, the withdrawal check, or the return of pension contributions.

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.

17:9-7.2 Termination of eligibility

(a) The coverage of an employee and such employee's eligible dependents shall terminate whenever such employ-

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

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.

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 State Health Benefits Program. 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 or spouse. It does not provide for a leave due to the personal illness of the employee.