

CHAPTER 9

STATE HEALTH BENEFITS PROGRAM

Authority

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

Source and Effective Date

R.1998 d.406, effective July 13, 1998. See: 30 N.J.R. 1919(a), 30 N.J.R. 2953(c).

Executive Order No. 66(1978) Expiration Date

Chapter 9, State Health Benefits Program, expires on July 13, 2003.

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).

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.1986 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).

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: Source and Effective Date.

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 Commission shall meet, as necessary, at the call of the chairman or the secretary.

(b) Any two members of the Commission shall constitute a quorum for the purpose of conducting the business of the Commission.

(c) If a member is unable to attend a meeting, he shall designate a person to represent him as his alternate. The person so designated shall be permitted to vote on business brought before the Commission.

**17:9-1.2 Records**

(a) The minutes of the Commission meetings are public records and may be inspected during regular business hours at the office of the Division of Pensions under supervision of the Chief of the Health Benefits Bureau or other representatives of the office.

(b) Records considered confidential include all matters related to the coverage of individual participants and their families, mailing addresses of active and retired participants and individual files related to major medical claims where no official purpose or reason for inspection is indicated.

**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).

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".

#### 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).

#### 17:9-5.6 Health maintenance organization charges

For purposes of State and local coverage, the employer who pays any portion of the cost for the employee and for dependent coverage cannot pay any more for the same type of coverage if the employee enrolls himself or herself and his or her dependents in a health maintenance organization as an alternative program. If the cost of the coverage in the alternative plan exceeds the cost of the State program, the additional charge would be collected by payroll deductions from the employee.

Amended by R.1974 d.228, eff. August 19, 1974.

See: 6 N.J.R. 156(a), 6 N.J.R. 360(c).

Amended by 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".

Administrative Correction.

See: 24 N.J.R. 4068(b).

#### 17:9-5.7 State and local; multiple coverage refunds

In the case of State and local coverage, when a husband and wife have secured coverage in the health benefits program as a result of one of them being employed by the State and the other by a local employer who has adopted the program, a refund is possible in the case of an employee of a local employer who is paying the full cost of dependent coverage for a spouse, who is an employee of the State and eligible for coverage but who has rejected such coverage.

Amended by R.1973 d.8, eff. January 4, 1973.

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

#### 17:9-5.8 Medicare refunds

(a) Each active employee, as well as the employee's spouse, who is covered under Part B of the Federal Medicare program, shall receive a refund of the amount paid for Part B semiannually.

(b) All refunds for subgroups of the State are accomplished with the preparation and submission to the Health Benefits Bureau of a claim for refund form duly signed by

the employee claiming the refund as verified from the records of the program.

(c) The State centralized payroll unit will process similar claims for refund by State employees paid by that agency.

(d) The local employer is responsible for refunds to any of his or her active employees, as well as the employee's spouse, who are covered under Part B of the Federal Medicare Program.

(e) All refunds will be made payable to the active or retired employee constituting the most timely charge payment for Part B coverage.

(f) Similar reimbursement will be made by the State and local employers, who have adopted the necessary resolution, to eligible retired employees for himself or herself and the retired employee's spouse, but in no event shall duplicate refunds be made to any employee for himself or herself or his or her spouse.

(g) Since Medicare premiums 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 within the 12 months immediately preceding the date of submission for the appropriate claim for refund form by the employee. Medicare Part B premiums paid prior to the 12 months immediately preceding the date of submission of the appropriate claim for refund form are not eligible for reimbursement.

Amended by R.1973 d.285, eff. October 2, 1973.

See: 5 N.J.R. 243(a), 5 N.J.R. 393(a).

Amended by R.1978 d.442, eff. December 26, 1978.

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

Amended by R.1981 d.139, eff. June 4, 1981.

See: 13 N.J.R. 110(c), 13 N.J.R. 376(c).

(g) added.

Amended by 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 "charges" and "his" to "his or her".

#### Case Notes

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).

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).

#### 17:9-5.9 Refunds rejected

Any request for refund not specified in N.J.A.C. 17:9-5.7 and 5.8 shall be denied. For example, a husband and wife may be employed in the same or in different locations, each location participating in the State Health Benefits Program and both having family coverage, or both having husband and wife coverage; in spite of the apparent duplication of

coverage, neither of the covered employees would be eligible for a refund. Or, the wife carries only single employee coverage under the State program while her husband 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 State program. Or, if one spouse applies for Medicare reimbursement for himself or herself and his or her spouse, 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).

#### 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.

#### 17:9-5.10 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 date the employee is actually enrolled.

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".

#### 17:9-5.11 Charges and coverage; 10-month employees

(a) Employees hired as of September 1 under a 10-month contract shall have charges 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, provided their employment resumes in September.

(b) Regarding 10-month contract State employees paid on a biweekly basis, 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).

#### 17:9-5.12 Premium-sharing for active employee State Health Benefits Coverage

(a) All State employees for whom there is no majority representative for collective negotiations purposes shall be subject to payroll deductions for Traditional Plan and HMO coverage in advance of the coverage period in accordance with standard payroll procedures as set forth in this section.

(b) For employees hired before December 11, 1995, payroll deductions for Traditional Plan coverage shall be determined as follows:

1. Effective with the coverage period commencing on July 1, 1996 for State monthly sub-groups, and July 6, 1996 for State bi-weekly sub-groups 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, employees with a base salary of \$50,000 or more shall pay the difference between the cost of the Traditional Plan and the average cost to the State for NJ PLUS and participating HMOs as determined hereafter. Employees with a base salary of less than \$50,000 shall pay, on a monthly basis, one percent of base salary but not less than \$20.00 per month.

2. Effective with the coverage period commencing on July 1, 1997 for State monthly sub-groups, and the first day of the bi-weekly coverage period closest to July 1, 1997 for State bi-weekly sub-groups and ending June 30, 2000 for monthly and bi-weekly sub-groups, employees with a base salary of \$40,000 or more shall pay the difference between the cost of the Traditional Plan and the average cost to the State for NJ PLUS and participating HMOs as determined hereinafter. Employees with a base salary of less than \$40,000 shall pay, on a monthly basis, one percent of base salary but not less than \$20.00 per month.

(c) Employees hired on or after December 11, 1995 shall pay the difference between the cost of the Traditional Plan and the average cost to the State for NJ PLUS and participating HMOs as determined hereinafter, effective with the coverage period commencing on July 1, 1996 for State monthly sub-groups, and July 6, 1996 for State bi-weekly sub-groups and ending June 30, 2000 for monthly and bi-weekly sub-groups.

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

1. Multiply the number of employees 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 PLUS and each participating HMO.

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

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

(e) Effective with the coverage period commencing on July 1, 2000, for State monthly and bi-weekly sub-groups:

1. Employees who elect coverage in the Traditional Plan shall pay 25 percent of the cost of that plan's premium as established by the State Health Benefits Commission pursuant to N.J.S.A. 52:14-17.32b;

2. Employees who elect coverage in an HMO Plan shall pay five percent of the cost of that plan's premium as established by the State Health Benefits Commission pursuant to N.J.S.A. 52:14-17.32b; and

3. Employees who elect coverage in NJ PLUS, the State of New Jersey Managed Care/Point of Service plan, shall have no premium 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).

## SUBCHAPTER 6. RETIREMENT

### 17:9-6.1 Retired employee defined

(a) "Retired employee" means a person who is eligible for coverage under the program, or under the health insurance plan of the person's employer where the employer is not participating in the program and the person is eligible to participate under P.L. 1987, c.384, immediately preceding retirement and receives a periodic retirement allowance from a State or locally administered retirement system or plan upon retirement. This "retired employee" status, once established, will continue in effect even though the employer is subsequently disbanded and no successor agency is created upon the dissolution of such employer. An employee who continued his or her coverage while on an official leave of absence for illness without pay but whose coverage terminated when his or her leave exceeded the period established by the statute for the continuation of coverage for such leave, will be permitted to elect to continue health benefits coverage into retirement provided such leave was in effect immediately preceding the date of his or her retirement.

(b) The definition of "retired employee" shall include the spouse of the employee, provided he or she was covered as a dependent under the Health Benefits Program immediately preceding the retirement or the death of the active or retired employee, and further provided that in the case of death of an active employee, the spouse is receiving a periodic pension or survivorship benefit from a State or locally administered retirement system or plan.

(c) 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.

1. 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 he or she is entitled is being granted by reason of his or her age or disability and coverage based on his or her employment with Rutgers University.

2. The Personnel Office of Rutgers University shall act as a collection officer for the collection of the charges required on a direct payment basis from the employees.

3. This payment shall be required from the employee on a quarterly basis in advance of coverage paid with the monthly billing.

(d) The definition of "retired employee" shall also include an employee who is eligible to receive a monthly annuity from the Teachers' Insurance and Annuity Association or long-term disability benefits based on his or her participation in the New Jersey Alternate Benefit Program, provided the employee who is receiving a monthly annuity applied for and began receiving a TIAA annuity immediately following the termination of his or her employment in a position covered by the Alternate Benefit Program, and further provided, that TIAA agrees to deduct the appropriate charge from the retired employee's monthly TIAA annuity and remits it promptly to the State Health Benefits Program as a remitting officer.

(e) The definition of "retired employee" shall include any former employee who retired from a State or locally administered retirement system on or after July 1, 1964, or the spouse of the former employee of an employer who becomes a participating employer if the employee or spouse:

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 State Health Benefits Program at the time the employer becomes a participating employer.

(f) The definition of "retired employee" shall include an employee who is eligible for continuation of coverage in the program at the time of retirement who terminates coverage at that time because he or she is covered as a dependent of another covered employee or as an active employee and who applies for continuation of coverage within a reasonable time after termination of coverage as a dependent or active employee.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Substantially amended.

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

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

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

#### 17:9-6.2 Coverage for prospective retirees

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

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

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

3. Should coverage lapse through no fault of the retired employee of his or her spouse who would be

eligible to continue such coverage, retroactive coverage may be granted, provided charges are received.

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

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

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

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

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

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

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

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

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

### 17:9-6.3 Retired coverage; limitation

(a) A retiree may change coverage to include a spouse and other dependents by submitting a completed application within 60 days of a change in family status (marriage or divorce, birth or adoption of a child, death or a significant change in health coverage due to spouse employment). The dependent shall be enrolled retroactively to the date of eligibility.

1. If a retiree wishes to add an eligible spouse or dependent and the completed application 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 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) Pensioners, whose original retirement allowance or pension is less than the charge to be deducted to pay for the cost of the coverage to such pensioner, will be permitted to continue coverage provided that the pensioner pays for the cost of such coverage in advance on a quarterly basis, in which case there will be no pension deduction.

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

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

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

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

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

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

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

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

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

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

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

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

(a)-(b) substantially amended.

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

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

(e) added.

Amended by R.1996 d.552, effective December 2, 1996.

See: 28 N.J.R. 3715(a), 28 N.J.R. 5079(a).

### Case Notes

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

### 17:9-6.4 Disability earnings

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

R.1976 d.313, eff. October 8, 1976.

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

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

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

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

### 17:9-6.5 Discontinuance of allowance

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

R.1976 d.313, eff. October 8, 1976.

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

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

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

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

#### 17:9-6.6 Beneficiary, dependent or survivor

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

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

R.1976 d.313, eff. October 8, 1976.

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

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

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

The word "premium" was changed to "charge".

Amended by R.1986 d.424, effective October 20, 1986.

See: 18 N.J.R. 1452(a), 18 N.J.R. 2135(d).

(b) added.

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

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

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

(c) Persons eligible to participate in the program under this section shall participate in the retiree group. If there is a widow or widower, or surviving spouse, eligible children shall participate as dependents of the widow or widower, or surviving spouse. If there is no widow or widower, or surviving spouse, eligible children shall participate as mem-

bers 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).

#### 17:9-6.8 Premium-sharing for retired employee State Health Benefit Coverage

(a) All State employees who accrue 25 years of service credit in a State-administered retirement system or retire on disability retirement after July 1, 1997, for whom there is no majority representative for collective negotiations purposes, 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 and be subject to payroll deductions for Traditional Plan coverage in advance of the coverage period in accordance with standard payroll procedures as set forth below.

(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 Traditional Plan coverage shall be determined 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 Traditional Plan and the average cost for NJ PLUS 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 differ-

ence between the cost of the Traditional Plan and the average cost to the State for NJ PLUS and participating HMOs as determined hereinafter.

(d) The average cost for NJ PLUS 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 PLUS 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 PLUS 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 PLUS 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 or retire on a disability retirement after July 1, 2000, payroll deductions for Traditional Plan coverage shall be determined as follows:

1. Retirees electing the Traditional Plan shall pay 25 percent of the cost of that plan's premium as established by the State Health Benefits Commission pursuant to N.J.S.A. 52:14-17.32b; and
2. Retirees electing NJ PLUS, the State of New Jersey Managed Care/Point of Service Plan, or an HMO shall have no premium payment.

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).

#### **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 CPFPPF; 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) or a position 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, CPFPPF, 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 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 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 premium or periodic charges for health benefits under the SHBP 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 July 1, 1998;

3. A retiree of an employer other than the State for whom the employer pays premium or periodic charges for health benefits as authorized by N.J.S.A. 40A:10-23 and pursuant to a collective negotiations agreement, ordinance, or resolution, for the life of the retiree, on July 1, 1998;

4. A retiree of an employer other than the State for whom the employer pays premium or periodic charges for health benefits as authorized by N.J.S.A. 40A:10-23, 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 the amount of the premium or periodic charges, on 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.

New Rule, R.1999 d.373, effective November 1, 1999.  
See: 31 N.J.R. 2300(b), 31 N.J.R. 3524(b).

#### **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).