

(b) 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 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.

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 Former N.J.A.C. 17:9-1.7, Guidelines; local employers; purchase of contracts, repealed.

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.

“Base salary” means an employee’s annual base salary as of the first pay period of the calendar year.

“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, parent and child, and family coverage, and for retirees only, with and without Medicare.

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

“NJ PLUS” is the name of the State’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.

“State biweekly sub-group” means a State payroll location or employment unit that is paid through the State Centralized Payroll System and reports to the program on a biweekly basis.

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

“Subscriber” means the person in whose name the coverage is listed.

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.

SUBCHAPTER 2. COVERAGE

17:9-2.1 Enrollment and charges

For local participating employers, each eligible employee shall be eligible to enroll for coverage without cost to the employee; and each employee’s eligible dependents shall be eligible for enrollment provided that the charges for such coverage shall be paid by the employee as required by the employer. For employees of the State and local participating employers, 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.

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 State Health Benefits Program options. A dependent must be listed on the enrollment form to be enrolled for coverage. If more than 60 days have passed since first eligibility 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 on the first coverage period in January.

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.

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 the first coverage period in January.

(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 State Health Benefits 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.

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 family, dependency or employment status of the employee or the employee's dependents. Such changes will be permitted under the following conditions:

1. *Marriage.* Any employee who marries may enroll the employee, or the employee and the employee's spouse and eligible dependents, if any, for any appropriate type of coverage by completing and forwarding a new enrollment form within the period beginning 60 days prior to the marriage and ending 60 days after such marriage. In the event that the spouse of such employee is already enrolled as an employee, the provisions of N.J.A.C. 17:9-3.5 shall apply to such spouse's enrollment.

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

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

6. *An employee, spouse or dependent ceases to be covered.* If the employee, spouse or other dependent declined State Health Benefits Program coverage due to other group health coverage, and then becomes ineligible for that other coverage due to qualifying events such as termination of employment, divorce, death, or reduction in hours worked, the individual may enroll in the State Health Benefits Program 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. *Upon the divorce of a dependent child.* An employee may enroll, for any coverage, a child under age 23 who, following a divorce, resides with the parent and is financially dependent upon the parent. 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 in order to obtain coverage retroactively to the date of the divorce. 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.

(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 State Health Benefits Program 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 State Health Benefits Program 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.

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 of Pensions and Benefits within the prescribed time limits; and
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.

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.

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 the Traditional Plan, NJ PLUS or an eligible HMO in the new area.

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.

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, 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 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.

17:9-2.11 Traditional Plan major medical and out-of-network NJ PLUS; 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 Traditional Plan major medical coverage or out-of-network NJ PLUS.

(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 Traditional Plan major medical or out-of-network NJ PLUS coverage.

(c) The charges considered are to be eligible charges under the Traditional Plan major medical or out-of-network NJ PLUS contract and no charges will be considered that would have been paid by the basic plan, had the employee had such coverage. 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.

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.

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 State Health Benefits Commission adopts by reference all of the policy provisions contained in the contracts between the health and dental plans and the State Health Benefits Commission as well as any subsequent amendments thereto, to the exclusion of all other possible coverages.

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.

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).

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, and foster children 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 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, covered by their parents under the State Health Benefits Program 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 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 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.”

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).

17:9-3.2 Military service

A spouse 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”.

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 such listing of the dependent shall constitute the required certification that at the time of enrollment such dependent is wholly dependent upon the employee for support and maintenance.

(b) A person who, although listed as an eligible dependent, is found to be ineligible or whose eligibility cannot be verified subsequent to enrollment shall be removed from coverage by the State Health Benefits Program and the contract level of the employee or retiree shall be adjusted accordingly. Coverage for that person as a dependent shall be restored retroactively to the date of eligibility if acceptable documentation is provided to the Division of Pensions and Benefits, 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. Examples of acceptable documentation include birth certificates, sworn affidavits, marriage certificates, 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.

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.

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 State Health Benefits Program’s medical advisor. A form requesting continuance of enrollment for an eligible dependent with disabilities must be submitted to the State Health Benefits Program 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 State Health Benefits Program who are determined by the State Health Benefits Program’s medical advisor 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 State Health Benefits Program; or

2. They were covered as dependents under a public employer’s group plan immediately preceding their parents’ entrance into the State Health Benefits Program under the provisions of N.J.S.A. 52:14-17.32f (qualified retirees of the Teachers’ Pension and Annuity Fund), N.J.S.A. 52:14-17.32f1 (qualified retirees of the Public Employees’ Retirement System who retired from boards of education or county colleges), N.J.S.A. 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 Inter-governmental 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.

17:9-3.5 Multiple coverage; employee and spouse

(a) For Traditional Plan coverage, an employee who is the spouse 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 as an employee while covered as a dependent. The employee of an employer other than the State, who has enrolled such spouse, and who is required to pay the full cost of dependent coverage, may receive a refund from the Division of Pensions and Benefits equivalent in amount to the employer’s cost for single coverage pursuant to N.J.S.A. 52:14-17.31. When both husband and wife 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 who is an employee of the State and eligible for coverage.

(c) If a husband and wife 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, under the Traditional Plan or NJ PLUS, but only one may elect coverage for the employee and for their qualified dependents, including the spouse, 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.

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.

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;

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, in the Traditional Plan, the employer must remit to the Division of Pensions and Benefits 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 of Pensions and Benefits, 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.

17:9-5.3 Local employer payment of dependent charges

(a) The statute requires the employer to pay the employee's cost of the coverage and may pay any portion of the cost for the dependent coverage.

(b) Any employer who elects to pay any portion of the cost for dependent coverage shall pay the same proportion of the cost of such dependent coverage for all employees covered in the program.

(c) However, when a local employer submits a resolution provided by the State Health Benefit Commission to change the amount paid toward the cost of dependent coverage, all employees must be resolicited with respect to coverage for themselves and their dependents.

(d) The employer shall give all employees an opportunity for completing, and forwarding a new enrollment form within 60 days following the employer's assumption of the dependent premium charges.

(e) Any 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.

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.

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, 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 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 Traditional, NJ PLUS, 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 subsection (a) of this section.

(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 Chapter 88 to surviving spouses 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 Chapter 88 to those former employees who retired since the employer adopted the provisions of the State Health Benefits Program 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 service credit and 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.

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 authorized by law, a participating local employer paying for the cost of coverage for enrollment in a SHBP Plan for a retiree subscriber may reimburse the retiree for all or part of the cost of Part B of the Federal Medicare program for the retiree subscriber and enrolled spouse, as appropriate. The participating local employer is responsible for the payment of such reimbursements.

(b) All reimbursements made pursuant to (a) above shall be made payable to the retiree subscriber constituting the most timely charge 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.

(c) In no event shall duplicate reimbursements be made to any subscriber for the subscriber or the subscriber's spouse.

(d) For retirees of the State, since Medicare Part B 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 on the appropriate claim for reimbursement form by the retiree subscriber. Medicare Part B premiums paid prior to the 12 months immediately preceding the date of submission of the appropriate claim for reimbursement form are not eligible for reimbursement.

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.

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 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 member and spouse coverage; in spite of the apparent duplication of coverage, neither of the covered employees would be eligible for a refund. Or, the spouse 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 State program. Or, if one spouse applies for Medicare reimbursement for the member and 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).
 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.

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.

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 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).

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 as N.J.A.C. 17:9-5.6.

(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 employer-paid 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 State Health Benefits Program (SHBP) who:

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

ii. Were eligible for employer-paid 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 the full Federal Medicare program; and

iii. Elect to join the SHBP under the provisions of P.L. 1993, c.8 (N.J.S.A. 52:14-17.32h);

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

6. Qualified retired employees of participating local employers who retired before the employer joined the State Health Benefits Program 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 State Health Benefits Program 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

SUBCHAPTER 6. RETIREMENT

17:9-6.1 Retired employee defined

(a) "Retired employee" means a person who is eligible for coverage under the State Health Benefits Program'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.

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 State Health Benefits Program 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 of an active or retired employee, provided the spouse was covered as a dependent under the State Health Benefits Program 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 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 of the employee, provided the spouse 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 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.

(i) 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 the employee 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.

(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.

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 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 of Pensions and Benefits, the local retirement system, or the investment carrier under the Alternate Benefits Program.

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 or the retired employee's spouse 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 State Health Benefits Program. The retired employee or eligible survivor must, within a 30-day period following the receipt of the letter offering retired continuing 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.

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.

17:9-6.3 Retiree coverage; limitation

(a) A retiree, but not the retiree's surviving spouse or dependent, 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, birth or adoption of a child, or a significant change in health coverage due to spouse employment). The dependent shall be enrolled retroactively to the date of the qualifying event.

1. If a retiree, but not the retiree's surviving spouse or dependent, 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) Retired employees, whose original retirement allowance or pension is less than the charge to be deducted to pay for the cost of the coverage to 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 or pension check.

(c) If the retired employee moves and is no longer able to be serviced by a health maintenance organization (HMO) or the NJ PLUS network, or the HMO in which the retired employee is enrolled is terminated, the retired employee will have a 30-day period to select coverage under another SHBP Plan.

(d) 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 complete Federal Medicare coverage Part A and B, is ineligible for coverage under the SHBP.

(e) A retired employee 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 and Benefits.

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.

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.

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.

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 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. If the surviving spouse is not the recipient of any monthly retirement allowance from a State-administered retirement system upon the death of the retired member, the Division of Pensions and Benefits will bill the surviving spouse 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.

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 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 surviving spouse, eligible children shall participate as dependents of the surviving spouse. If there is no surviving spouse, eligible children shall participate as members of the program, and their eligibility to participate shall continue as long as they qualify as children under the laws governing the retirement system of the deceased member.

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

New Rule, R.1990 d.481, effective October 1, 1990.

See: 22 N.J.R. 1903(b), 22 N.J.R. 3158(c).

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.

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 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. 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 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 difference 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 or an HMO shall have no premium payment.

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

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).

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), 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, 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 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 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.

“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 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) As a pilot program for six years (from March 20, 2000 to March 20, 2006), 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 plan. Payment for prescription drug expenses or the co-payments required under the prescription drug 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 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 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 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.

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.

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 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; 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.

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
Authority

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

Source and Effective Date

R.2004 d.191, effective May 17, 2004.
See: 36 N.J.R. 22(a), 36 N.J.R. 2423(a).

Subchapter Historical Note

Subchapter 11, Part-Time Employees Group, was adopted as R.2004 d.191, effective May 17, 2004. See: Source and Effective Date.

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

(a) The State Health Benefits Program 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 regulations governing the State Health Benefits Program, 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 Consolidated Omnibus Budget Reconciliation Act of 1985, 29 U.S.C. §§ 1161-1168 (COBRA) law, coverage is not continued in the event of death, or other termination of the group coverage. There is no right of conversion from the Part-Time Employees Group to nongroup 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.

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, as well as part-time faculty at county colleges participating in the SHBP, are eligible to enroll if they are members of the State-administered retirement system.

17:9-11.3 Coverage available

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

(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 PLUS. Members shall also be eligible for coverage under the State Employee Prescription Drug Plan. There shall be no prescription drug coverage under NJ PLUS.

(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 PLUS.

(d) There is no eligibility for dental or vision or any other benefit created by P.L. 2003, 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 State Health Benefits Commission may adopt separate rates for the Part-time Employees Group reflecting the actual cost of the benefit plus administrative costs.

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 employer-paid 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.

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 PLUS immediately prior to retirement shall be eligible to continue NJ PLUS coverage as a retiree at their own expense. Prescription drug benefits under NJ PLUS 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 or pension checks. Where the available retirement allowance or pension check 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 will be offered the opportunity to continue participation in NJ PLUS 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 must pay the full costs.

SUBCHAPTER 12. RETIREE DENTAL EXPENSE PLAN**Authority**

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

Source and Effective Date

R.2004 d.63, effective February 22, 2005.
See: 36 N.J.R. 4692(a), 37 N.J.R. 628(a).

17:9-12.1 The 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 State Health Benefits 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 State Health Benefits Program as administered by the State Health Benefits 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 State Health Benefits Program. There is no eligibility to continue retired dental coverage under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985, 29 U.S.C. §§ 1161 through 1168 (COBRA) law;
2. There is no right of conversion from the Plan to non-group coverage;
3. 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
4. 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.

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 preceding 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 preceding 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.