

CHAPTER 9

STATE HEALTH BENEFITS PROGRAM

Authority

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

Source and Effective Date

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

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1c, Chapter 9, State Health Benefits Program, expires on January 9, 2004. See: 35 N.J.R. 2587(a).

Chapter Historical Note

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Pursuant to Executive Order No. 66(1978), Chapter 9, State Health Benefits Program, was readopted as R.1998 d.406, effective July 13, 1998. See: Source and Effective Date.

Law Review and Journal Commentaries

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**SUBCHAPTER 1. ADMINISTRATION****17:9-1.1 Commission meetings**

(a) The Commission shall meet, as necessary, at the call of the chairman or the secretary.

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

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

**17:9-1.2 Records**

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

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

**Case Notes**

Board of education had sufficiently strong interest in obtaining information regarding health insurance claims paid for each employer

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

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

### 17:9-1.3 Appeals from Commission decisions

(a) Any member of the traditional plan or NJ PLUS plan who disagrees with the decision of one of the claims administrators may request that the matter be considered by the State Health Benefits Commission. Requests for consideration must be directed to the Secretary, State Health Benefits Commission, and must contain the reason for the disagreement. Appeals shall be considered at the regular monthly meetings of the Commission. It shall be the responsibility of the member to provide the Commission with any medical or other information that the Commission may require in order to make a decision.

(b) Any member of an HMO who disagrees with a determination of medical necessity made by an HMO or any member of an HMO who feels that the HMO has violated the terms and conditions of its contract may request that the matter be considered by the State Health Benefits Commission. Such an appeal can only be considered after the member has exhausted the HMO's grievance process. Appeals shall be considered at the regular monthly meetings of the Commission.

(c) Notification of all Commission decisions will be made in writing to the member and the following statement shall be incorporated in every written notice setting forth the Commission's determination in a matter where such determination is contrary to the claim made by the claimant or his or her legal representative:

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

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

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

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

As amended, R.1970 d.147, effective December 10, 1970.  
See: 2 N.J.R. 94(d), 3 N.J.R. 11(a).  
Amended by R.1996 d.551, effective December 2, 1996.  
See: 28 N.J.R. 4083(b), 28 N.J.R. 5078(c).

### Case Notes

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

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

### 17:9-1.4 (Reserved)

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

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

### 17:9-1.5 Voluntary termination of employer; notice

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

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

1. An employer who has terminated coverage more than once may submit a resolution for re-entry during the re-entry application period. The Commission shall con-

sider the relevant facts accompanying the resolution, including any hardship or emergency, the impact of re-entry on the program and individual members, and whether re-entry is consistent with statutory law or judicial determinations. The Commission shall approve or disapprove the resolution for re-entry and shall so notify the employer within 30 days following receipt of the resolution. If the Commission approves the re-entry, the re-entry shall be effective upon a date determined by the Commission, which date shall be not less than 60 days nor more than 365 days following the Commission's approval. The re-entry shall be contingent upon the employer's reimbursement to the Commission of administrative expenses reasonably based upon the approximate cost to the Commission of re-enrolling the employer.

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

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

Amended by R.1970 d.147, effective December 10, 1970.

See: 2 N.J.R. 94(d), 3 N.J.R. 11(a).

Amended by R.1976 d.124, effective April 22, 1976.

See: 8 N.J.R. 85(c), 8 N.J.R. 263(a).

Amended by R.1983 d.332, effective August 15, 1983.

See: 15 N.J.R. 793(a), 15 N.J.R. 1383(d).

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

Amended by R.1985 d.587, effective November 18, 1985.

See: 17 N.J.R. 1399(a), 17 N.J.R. 2784(b).

(b) Added text "for a period . . . permitted only once."

Amended by R.1993 d.269, effective June 7, 1993.

See: 25 N.J.R. 460(a), 25 N.J.R. 2505(d).

#### Case Notes

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

#### 17:9-1.6 Default of employer; notice

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

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

As amended, R.1970 d.147, effective December 10, 1970.

See: 2 N.J.R. 94(d), 3 N.J.R. 11(a).

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

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

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

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

Pursuant to the provisions of N.J.S.A. 52:14-17.25 et seq., it is the policy of the State Health Benefits Commission that when local governments purchase insurance contracts of health benefits, such as prescription drug, dental expense and vision care coverages, such contracts and coverage therein must adhere to the guidelines approved by the State Health Benefits Commission for such contracts or coverages, as such guidelines were transmitted to all public employers by the Division of Pensions. Local governments cannot deviate from such guidelines in purchasing such contracts or coverages without the approval of the State Health Benefits Commission.

As amended, R.1983 d.331, effective August 15, 1983.

See: 15 N.J.R. 884(a), 15 N.J.R. 1383(e).

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

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

#### 17:9-1.9 Definitions

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

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

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

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

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

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

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

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

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

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

## SUBCHAPTER 2. COVERAGE

### 17:9-2.1 Enrollment charges

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

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

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

### 17:9-2.2 Enrollment form

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

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

Added reference to female employees.

### 17:9-2.3 Annual enrollment period

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

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

maintenance organization or the health maintenance organization is terminated.

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

Amended by R.1974 d.228, effective August 19, 1974.  
See: 6 N.J.R. 156(a), 6 N.J.R. 360(c).  
Amended by R.1976 d.124, effective April 22, 1976.  
See: 8 N.J.R. 85(c), 8 N.J.R. 263(a).  
Amended by R.1978 d.131, effective April 18, 1978.  
See: 10 N.J.R. 80(b), 10 N.J.R. 265(b).  
Amended by R.1978 d.442, effective December 26, 1978.  
See: 10 N.J.R. 456(a), 11 N.J.R. 105(b).  
Amended by R.1983 d.44, effective March 7, 1983.  
See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).

The word “his” was changed to “his or her”.  
Amended by R.1985 d.18, effective February 4, 1985.  
See: 16 N.J.R. 2422(a), 17 N.J.R. 320(b).

(c) added.  
Amended by R.1993 d.259, effective June 7, 1993.  
See: 25 N.J.R. 4025(a), 25 N.J.R. 2506(a).

### 17:9-2.4 Coverage and plan changes; exceptions

(a) An employee may change the employee's enrollment and the enrollment of the employee's dependents to any type of coverage or plan if such changes result from a change in family, dependency or employment status of the employee or the employee's dependents, or if the employee moves out of the coverage area. 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 or plan by completing and forwarding a new enrollment form within the period beginning 60 days prior to the marriage and ending 60 days after such marriage. In the event that the spouse of such employee is already enrolled as an employee, the provisions of N.J.A.C. 17:9-3.9 shall apply to such spouse's enrollment.

2. *Divorce; separation.* Any employee who has been enrolled or has been covered as a dependent of an enrolled employee and is subsequently divorced may enroll in any plan, 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 or plan 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 or plan 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 or plan 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 or plan 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 or plan 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 or plan, 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 employee must have had that coverage in the active group.

10. *Upon return to employment from an approved leave of absence.* Upon return to employment from an approved leave of absence, the employee may elect to change coverage or plan to add the employee and any eligible dependent(s) who had been removed from this group coverage while the employee was on such leave.

(b) An employee may change the employee's enrollment and the enrollment of the employee's eligible dependents to any type of coverage or plan 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. 17:9-5.11(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.

#### 17:9-2.5 Employee coverage requirements

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

1. The master 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; and

4. An enrollment form has been legibly completed by the employee and registered by the State Centralized Payroll Section or the certifying agent of the local employer with the Health Benefits Bureau of the Division of Pensions within the prescribed time limits.

Amended by R.1973 d.8, effective Jan. 4, 1973.  
See: 4 N.J.R. 282(a), 5 N.J.R. 59(b).

#### 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; State employees and dependents

For State employees and their dependents for whom an enrollment application has been filed with the Division of Pensions, coverage is effective on the first day of the fifth payroll period of employment for a sub-group which reports on a bi-weekly basis, 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 HMO coverage, deductions begin on the first day of the third payroll period of employment for bi-weekly 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.

#### 17:9-2.7 Effective date; local employees and dependents

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

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.

#### 17:9-2.8 Effective date; ineligible employees and dependents

(a) An employee who, at the time of his or her coverage would otherwise become effective, is not actively at work on a full-time basis at his or her customary place of employment or other location to which his or her employment

requires him or her to travel, shall not be covered until he or she is so actively at work. Such employee shall be eligible for coverage immediately upon his or her return to active full-time work.

(b) The major medical coverage for a dependent (except a newborn child), who, at the time of his or her coverage would otherwise become effective, is confined in a medical facility primarily for medical care or treatment on the date the major medical coverage would otherwise become effective with respect to that dependent, will be deferred until his or her final medical release from all such confinement.

(c) Employees and dependents who cannot meet the requirements established by this rule, but who were covered under a major medical insurance plan of their public employer just prior to the employer's participation in the State program, shall be permitted to enroll.

As amended, R.1984 d.560, eff. December 17, 1984.  
See: 16 N.J.R. 2422(b), 16 N.J.R. 3479(b).  
Section substantially amended.

#### Cross References

Major medical benefits coverage, ineligible dependents, see N.J.A.C. 17:9-3.7.

#### 17:9-2.9 Transfers

(a) In order to provide mobility to employees of participating employers, as well as of the State, employees who transfer from one State payroll to another, or from one participating employer to another, or from the State to a participating employer, or from a participating employer to the State, 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 and the actively-at-work requirement in order to obtain the coverage again.

(b) For employees who will have the option of traditional coverage or electing HMO participation upon a transfer, as described in subsection (a) of this section, a 30-day period will be available for the selection of coverage during which period their former coverage will be continued.

As amended, R.1976 d.124, effective April 22, 1976.  
See: 8 N.J.R. 85(c), 8 N.J.R. 263(a).

#### Case Notes

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

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

**17:9-2.10 HMO; elections**

(a) Employees 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. The status of employees who have no HMO election to make will be the same as the described for employees who transfer. (See N.J.A.C. 17:9-2.9(a).)

(b) Employees 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 the former HMO; or
2. Transfer participation to an eligible HMO in the new area, if such is available in the new area; or
3. Transfer coverage into the traditional program.

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.

**17:9-2.11 Coverage for survivors**

(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 carrier underwriting the individual annuity contracts. If it is not necessary for a 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, the local retirement system, or the carrier.

(b) The eligible survivor of the deceased employee must submit personal payments to the health benefits program in order to continue coverage.

(c) Should coverage lapse through no fault of the survivor, who would be eligible to continue such coverage, retroactive coverage may be granted up to a period of three months, 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.

**17:9-2.12 Major Medical; eligible charges at enrollment (local employees)**

(a) For purposes of local coverage, all eligible charges incurred by an eligible employee or his or her covered dependents, from January 1 of a calendar year to the effective date of coverage for his or her participating employer, will be considered to satisfy the deductibles and copayments required under the Major Medical coverage. The above provision is contingent upon the eligible employee being actively at work on the effective date of coverage and his or her dependents not be deferred as stated under N.J.A.C. 17:9-2.8(b).

(b) The charges considered are to be eligible charges under the Major Medical 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 copayments for which the employee has been reimbursed by any source where any employer participated under another contract.

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".

**17:9-2.13 Major Medical; extension of coverage charges**

(a) For purposes of the payment of claims under the Major Medical contract, if immediately prior to his or her entry into the eligible classes an employee or dependent was covered under the extension of coverage provisions of the Major Medical contract, 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.

**17:9-2.14 Effective date; maternity benefits**

Effective January 1, 1973, maternity and obstetrical benefits are extended to employees and dependent wives with single, husband and wife, and parent and child coverage.

R.1973 d.148, eff. June 6, 1973.  
See: 5 N.J.R. 168(a), 5 N.J.R. 247(b).

**17:9-2.15 Major Medical; separate plans**

If the State or local employer adopts separate plans for all employees or for some portion of covered employees for prescription drug reimbursement, vision care, or other health care benefits, largely duplicating or minimizing the benefits provided under the Major Medical program, such services or benefits for the participants of such separate plans will no longer be considered eligible for reimbursement under the Major Medical program to the extent benefits are provided under such plans.

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).

**17:9-2.16 Policy provisions adoption**

The State Health Benefits Commission adopts by reference all of the policy provisions contained in the contracts between the carriers, the health maintenance organizations 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).

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 psycholo-

gist or medical doctor. *Goldman v. State Health Benefits Commission*. 93 N.J.A.R.2d (TYP) 18.

### 17:9-2.17 Chapters 384 and 386, Laws of 1987; enrollment of retirees

For the purposes of implementing Chapters 384 and 386 of the Laws of 1987, retirees of boards of education participating in the State Health Benefits Program who do not qualify for State payment of premiums for coverage and are not enrolled in the program may enroll within the one-year period from June 1, 1988 to May 31, 1989.

New Rule, R.1988 d.471, effective October 3, 1988.  
See: 20 N.J.R. 1537(a), 20 N.J.R. 2467(a).

## 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 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.

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.

### 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 during such military service.

### 17:9-3.3 Medicare

Any person who is otherwise eligible for benefits as a dependent of any active or retired employee, but who, although he is eligible to enroll in the Federal Medicare program, is not covered by the complete Federal program, would not be covered as a dependent.

As amended, R.1973 d.285, eff. October 2, 1973.  
See: 5 N.J.R. 243(a), 5 N.J.R. 393(a).

### 17:9-3.4 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).

### 17:9-3.5 Additional dependents

If, after having enrolled his or her dependent for coverage under family or parent-child coverage, an employee acquires one or more additional dependent children through birth or legal adoption and guardianship, such additional children shall be enrolled as dependents, if they are otherwise eligible.

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.1973 d.313, eff. October 8, 1976.

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

### 17:9-3.6 Basic benefits; ineligible dependents

(a) The basic benefits coverage of a dependent who, at the time his or her coverage would otherwise become effective, is confined in an institution for care and treatment, shall become effective as indicated below:

1. Hospital benefit shall be payable for confinements commencing on and after the effective date of coverage only; and
2. Medical/Surgical benefits shall be payable for services rendered on and after the effective date of coverage only.

### 17:9-3.7 Major Medical; ineligible dependents

The Major Medical benefits coverage for any dependent (except a newborn child) who, at the time his or her coverage would become effective, is confined in a medical facility primarily for medical care or treatment on the date that the Major Medical coverage would otherwise become effective with respect to that dependent, the coverage for that dependent will be deferred until his or her final medical release from all such confinement. See N.J.A.C. 17:9-2.8.

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).

Section substantially amended.

#### Cross References

State health benefits program, coverage changes, see N.J.A.C. 17:9-2.4.

### 17:9-3.8 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 Intergovernmental Transfer Program (established under N.J.S.A. 11A:2-11).

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

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

New Rule, R.2001 d.27, effective January 16, 2001.

See: 32 N.J.R. 3383(a), 33 N.J.R. 291(b).

### 17:9-3.9 Multiple coverage; employee and spouse

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.

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

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

### 17:9-3.10 (Reserved)

Amended by R.1976 d.313, effective October 8, 1976.

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

## 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. Delaware River Joint Toll Bridge Commission (Free Bridges);
3. Palisades Interstate Park Commission;
4. University of Medicine and Dentistry of New Jersey;
5. Agencies or special projects which are supported from or whose employees are paid from sources of revenue, other than general funds, which other funds shall 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.

#### 17:9-4.2 State; full-time defined

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

1. The normal full-time weekly schedule for the particular class title, and in any case not less than 35 hours per week;
2. Employment for 12 months, except in the case of those employees engaged in activities where the regular and normal work schedule is ten months;
3. Sabbaticals where the compensation paid is 50 percent or more of the salary granted just prior to the leave and the period of eligibility terminates with the end of the fiscal year;
4. Public defenders who are paid on the basis of an average 30-hour work week schedule, notwithstanding Section 4 of this Subchapter;
5. Employees of the University of Medicine and Dentistry of New Jersey who are paid for a minimum of 20 hours per week, notwithstanding N.J.A.C. 17:9-4.4;
6. Teaching assistants and graduate assistants at Rutgers, the State University, who are paid for a minimum of 15 hours, notwithstanding N.J.A.C. 17:9-4.4;
7. Deputy attorneys general in the Office of the Attorney General and the Divisions of Criminal Justice, Gaming and Law in the Department of Law and Public Safety, who are paid for a minimum of 20 hours per week, notwithstanding the provisions of N.J.A.C. 17:9-4.4, until June 30, 1994.

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

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

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

Amended by R.1975 d.68, effective March 14, 1975.

See: 7 N.J.R. 76(a), 7 N.J.R. 181(a).

Amended by R.1983 d.330, effective August 15, 1983.

See: 15 N.J.R. 792(b), 15 N.J.R. 1383(c).

Change name to University of Medicine and Dentistry of New Jersey.

Amended by R.1988 d.442, effective October 17, 1988.

See: 20 N.J.R. 741(a), 20 N.J.R. 2590(b).

Added (a)7.

Amended by R.1990 d.480, effective October 1, 1990.

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

Deleted text from (a)7 and inserted new.

Amended by R.1993 d.57, effective April 5, 1993.

See: 24 N.J.R. 2345(a), 25 N.J.R. 1518(a).

Revised (a)7.

Amended by R.1995 d.3, effective January 3, 1995.

See: 26 N.J.R. 2202(a), 27 N.J.R. 128(a).

#### Case Notes

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

#### 17:9-4.3 Ineligible employees defined

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

1. Any person with less than two months of continuous service;
2. Any person whose compensation is limited to reimbursement of necessary expenses actually incurred in the discharge of his official duties;
3. Any person compensated on a fee basis (see N.J.A.C. 17:9-4.5);
4. Any person who is employed on short-term, seasonal, intermittent or emergency basis such as a person whose compensation is in the nature of a "retainer", or is for occasional services or whose service is for brief periods at intervals, such as substitute teachers;
5. Any person whose compensation is paid or payable by voucher;
6. Any person whose services are not full-time;
7. Any person granted a sabbatical where the compensation paid is less than 50 percent of the salary granted just prior to the leave;
8. Any person who is an aide or patient employee in a State, county or municipal institution;
9. Any person, active or retired, who is otherwise eligible for benefits but who, although he is eligible to enroll in the Federal Medicare Program, is not covered by the complete Federal program.

Amended by R.1971 d.21, effective February 17, 1971.

See: 3 N.J.R. 10(a), 3 N.J.R. 52(c).

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

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

Amended by R.1978 d.441, effective December 26, 1978.

See: 10 N.J.R. 517(b), 11 N.J.R. 105(a).

**Case Notes**

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

**17:9-4.4 State; ineligible employees defined**

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

1. An hourly rate (payroll compensation code 7) except that a full-time employee with a Civil Service title assigned an hourly salary range is eligible;
2. A daily rate (payroll compensation code 8);
3. A rate per meeting, session (payroll compensation code 8);
4. A salary based on a percentage of full-time (payroll compensation code 6);
5. Any employee who is on a Federal payroll or combination of Federal and State payrolls;
6. Any person who is not on a State payroll;
7. Any person who is on the payroll of another state, whether or not such person is also on a New Jersey State payroll;
8. Any otherwise eligible employee for whom the State, directly or indirectly, provides benefits under any other plan, which benefits have a value equal to or in excess of the benefits payable under the State Employees Health Benefits Act.

**17:9-4.5 Local; employee defined**

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

**Case Notes**

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

**17:9-4.6 Local; full-time defined**

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

1. Employment of any eligible employees who appear on a regular payroll and who receive a salary or wages for an average of the number of hours per week as prescribed

by the governing body of the participating employer. Each participating employer shall, by resolution, determine the number of hours worked which shall be considered to be "full-time." In no case shall the number of hours for "full-time" be less than 20.

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

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

Amended by R.1983 d.43, effective March 7, 1983.  
See: 14 N.J.R. 1296(a), 15 N.J.R. 343(c).

Minimum hours per week changed to an average of hours per week.  
Amended by R.1995 d.644, effective December 18, 1995.

See: 27 N.J.R. 2680(a), 27 N.J.R. 5040(a).

Amended by R.1999 d.395, effective November 15, 1999.

See: 31 N.J.R. 2300(a), 31 N.J.R. 3742(a).

Added (b).

**Case Notes**

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

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

**17:9-4.7 Multiple positions**

For purposes of State and local coverage, "full-time" shall mean employment of an employee who holds multiple public positions at the same time, if the employee would otherwise be eligible for coverage in any one of such positions.

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

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

**SUBCHAPTER 5. CHARGES****17:9-5.1 Separate experience; State and local**

The experience of local employers should be considered separately from that of the State.

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

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

## Case Notes

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

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 Waiting period**

There shall be a two-month waiting period for local employer participation.

As amended, R.1973 d.8, eff. January 4, 1973.  
See: 4 N.J.R. 282(a), 5 N.J.R. 59(b).

**17:9-5.3 Advance charges; interest charges**

(a) For the purpose of local coverage, in the traditional program, the employer must remit to the Division of Pensions charges covering a one-month period in advance of the coverage date whereas charges for HMO coverage are remitted directly to the HMO in which the employee is enrolled.

(b) 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, 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.

**17:9-5.4 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 agrees to pay all of the cost for dependent coverage, all employees must be resolicited with respect to coverage for themselves and their dependents.

(d) The employer shall give all of his 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).

**17:9-5.5 Local employer resolution; Chapter 88, P.L. 1974; Chapter 54, P.L. 1979**

(a) A local employer will satisfy the requirements of Chapters 88, P.L. 1974 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 State is paying the cost of its eligible pensioners and their dependents in accordance with the provisions of Chapter 75, P.L. 1972;
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 Chapter 75, P.L. 1972 (see N.J.A.C. 17:9-5.8);
4. Require the local employer to pay the full cost of such charges;
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 Chapter 54, P.L. 1979. Such resolution shall meet the prescriptions of subsection (a) of this section.

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".

#### Case Notes

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

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

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

#### 17:9-5.6 (Reserved)

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

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

Amended by R.1983 d.44, eff. March 7, 1983.

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

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

Administrative Correction.

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

Repealed by R.2000 d.493, effective December 18, 2000.

See: 32 N.J.R. 3384(a), 32 N.J.R. 4450(a).

Section was "Health maintenance organization charges".

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

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

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

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

#### 17:9-5.8 Medicare refunds

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

(b) All refunds for subgroups of the State are accomplished with the preparation and submission to the Health Benefits Bureau of a claim for refund form duly signed by the employee claiming the refund as verified from the records of the program.

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

(d) The local employer is responsible for refunds to any of his or her active employees, as well as the employee's

spouse, who are covered under Part B of the Federal Medicare Program.

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

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

(g) Since Medicare premiums reimbursements are dependent upon sufficient, annual appropriations from the legislature, eligible reimbursements regarding Medicare Part B premiums will include only those premiums that have been paid within the 12 months immediately preceding the date of submission for the appropriate claim for refund form by the employee. Medicare Part B premiums paid prior to the 12 months immediately preceding the date of submission of the appropriate claim for refund form are not eligible for reimbursement.

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

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

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

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

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

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

(g) added.

Amended by R.1983 d.44, eff. March 7, 1983.

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

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

#### Case Notes

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

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

#### 17:9-5.9 Refunds rejected

Any request for refund not specified in N.J.A.C. 17:9-5.7 and 5.8 shall be denied. For example, a husband and wife may be employed in the same or in different locations, each location participating in the State Health Benefits Program and both having family coverage, or both having husband and wife coverage; in spite of the apparent duplication of coverage, neither of the covered employees would be eligible for a refund. Or, the wife carries only single employee coverage under the State program while her husband is covered by a plan in private industry where the employer pays for employee and dependent coverage; no refund would be payable since both would have to have been in public employment covered by the State program. Or, if one spouse applies for Medicare reimbursement for himself

or herself and his or her spouse, the other shall not receive duplicate reimbursement.

Amended by R.1973 d.8, eff. January 4, 1973.  
See: 4 N.J.R. 282(a), 5 N.J.R. 59(b).  
Amended by R.1976 d.313, eff. October 8, 1976.  
See: 8 N.J.R. 443(c), 8 N.J.R. 539(a).

#### Case Notes

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

#### 17:9-5.10 Retroactive charges; payment due

Retroactive charges covering the entire period of retroactivity will be calculated on the basis of the charge in effect on the date the employee is actually enrolled.

R.1975 d.159, eff. June 9, 1975.  
See: 7 N.J.R. 118(e), 7 N.J.R. 349(b).  
As amended, R.1983 d.44, eff. March 7, 1983.  
See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).  
"premiums" was changed to "charges".

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

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

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

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

R.1978 d.131, eff. April 18, 1978.  
See: 10 N.J.R. 80(b), 10 N.J.R. 265(b).  
As amended, R.1982 d.341, eff. October 18, 1982.  
See: 14 N.J.R. 36(a), 14 N.J.R. 1165(a).  
Clarified coverage of biweekly cases of 10-month employees.  
As amended, R.1983 d.330, eff. August 15, 1983.  
See: 15 N.J.R. 792(b), 15 N.J.R. 1383(c).  
The word "premiums" replaced by "charges".  
Amended by R.1989 d.335, effective July 3, 1989.  
See: 21 N.J.R. 886(a), 21 N.J.R. 1836(a).

Provisions governing coverages and charges for 10-month employees added at (c).

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

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

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

1. Effective with the coverage period commencing on July 1, 1996 for State monthly sub-groups, and July 6, 1996 for State bi-weekly sub-groups and ending June 30, 1997 for monthly sub-groups and the last day of the payroll period closest to July 1, 1997 for bi-weekly sub-groups, employees with a base salary of \$50,000 or more shall pay the difference between the cost of the Traditional Plan and the average cost to the State for NJ PLUS and participating HMOs as determined hereafter. Employees with a base salary of less than \$50,000 shall pay, on a monthly basis, one percent of base salary but not less than \$20.00 per month.

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

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

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

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

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

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

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

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

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

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

New Rule, R.1996 d.298, effective June 17, 1996.  
See: 28 N.J.R. 1944(a), 28 N.J.R. 3171(a).  
Amended by R.2000 d.298, effective July 17, 2000.  
See: 32 N.J.R. 1322(a), 32 N.J.R. 2601(b).

In (a), inserted a reference to HMO coverage; in (b), inserted "and ending June 30, 1997 for monthly sub-groups and the last day of the payroll period closest to July 1, 1997 for bi-weekly sub-groups" in the first sentence of 1, and inserted "and ending June 30, 2000 for monthly and bi-weekly sub-groups" in the first sentence of 2; in (c), added "and ending June 30, 2000 for monthly and bi-weekly sub-groups" at the end; and added (e).

## SUBCHAPTER 6. RETIREMENT

### 17:9-6.1 Retired employee defined

(a) "Retired employee" means a person who is eligible for coverage under the 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.

(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

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 by the Board of Trustees of the retirement system paying the benefit or by the carrier underwriting the individual annuity contracts.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a)-(b) substantially amended.

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

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

(e) added.

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

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

#### Case Notes

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

### 17:9-6.4 Disability earnings

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

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

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

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

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

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

### 17:9-6.5 Discontinuance of allowance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) added.

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

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

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

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

#### 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 N.J.S.A. 52:14-17.32i et seq.

1. A retired State employee whose premium or periodic charges for health benefits under the State Health

Benefits Program are paid by the State pursuant to section 8 of P.L. 1961, c.49 (N.J.S.A. 52:14-17.32) or section 6 of P.L. 1996, c.8 (N.J.S.A. 52:14-17.28b);

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

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

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

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

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

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

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

#### 17:9-6.10 Retiree prescription drug card plan

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

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

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

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

“Preferred brands” means brand name prescription drug products and insulin determined by the provider, to be more cost effective alternatives for prescription drug products and insulin with comparable therapeutic efficacy within a therapeutic class, as defined or recognized in the United States Pharmacopeia or the American Hospital Formulary Service Drug Information, or by the American Society of Health Systems Pharmacists. A drug product for which there is no other therapeutically equivalent drug product shall be a preferred brand. Determinations of preferred brands by the provider shall be subject to review and modification by the Commission.

“Prescription drug card plan” or “card plan” means the plan for providing payment for eligible prescription drug expenses of retired members of the State Health Benefits Program and their eligible dependents who participate in the Traditional Plan or the State managed care plan (NJ PLUS) as prescribed by this section.

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

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

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

(b) As a pilot program for five years (from March 20, 2000 to March 20, 2005), payment for eligible prescription drug expenses of retired members of the State Health Benefits Program and their eligible dependents who participate in the Traditional Plan or NJ PLUS shall be provided under the prescription drug card plan. Payment for prescription drug expenses or the co-payments required under the card plan shall not be made under the major medical portion of the Traditional Plan or NJ PLUS. There shall be no annual deductible amount that retired members or their eligible dependents shall satisfy before eligibility for payment of prescription drug expenses under the card plan.

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

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

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

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

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

(g) The amount of out-of-pocket expense that a retired member or eligible dependent shall pay for a calendar year for eligible prescription drug expenses under the card plan

shall be limited initially for calendar years 2000 and 2001 to \$300.00.

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

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

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

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

1. To limit excessive annual increases which are significantly higher than the trends for the increases over the preceding five years;
2. To maintain an appropriate spread between the categories of co-payment amounts; or
3. To prevent undue hardship to retirees if general economic circumstances in the State or economic circumstances relative to health care for retirees are such that strict application of the formulas for the annual increases in the co-payments or the maximum out-of-pocket expense would produce such hardship.

New Rule R.2000 d.116, effective March 20, 2000.

See: 31 N.J.R. 4235(a), 32 N.J.R. 1048(a).

Notice of increase in co-payments and maximum out-of-pocket expenses, effective January 1, 2002.

See: 33 N.J.R. 3774(a).

Public Notice: Notice of increase in co-payments and out-of-pocket expenses, effective January 1, 2004.

See: 35 N.J.R. 4791(b).

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

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

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

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

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

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

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

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

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

New Rule, R.2003 d.185, effective May 5, 2003.

See: 35 N.J.R. 87(a), 35 N.J.R. 1925(a).

## SUBCHAPTER 7. TERMINATION

## 17:9-7.1 Termination effective date

Cessation of active full-time employment shall be deemed to occur on the last day of the coverage period for which charges have been paid.

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".

## 17:9-7.2 Termination conversion rights; effective dates

(a) The coverage of an employee and such employee's dependents shall be terminated; subject to the conversion rights, whenever such employee's eligibility shall cease for any of the reasons given in subsection (c) of this section.

(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 the coverage of dependents, if any are required, or the last charge shall have been paid by the State for the employee's and/or his or her dependents' coverage or by the local employer for the employee and/or his or her dependents, as the case may be.

(c) The reasons for the termination of eligibility are as follows:

1. Leave of absence without pay: 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; except that 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.

2. Change to part-time status. In the event that an employee's active full-time employment shall cease and employee shall become a "part-time" employee, such employee's coverage, and the coverage of such employee's dependents, shall be terminated.

3. An employee whose coverage terminated as a result of a change from full-time to part-time status cannot be reenrolled until he or she has reestablished his or her 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 coverage of an employee whose eligibility has ceased because of his or her resignation, temporary layoff, separation through a reduction in force, or any other reason, and the coverage of his or her dependents shall be terminated subject to the conversion rights.

5. An employee, who has an award pending, or who received an award of periodic benefits under Workers' Compensation, may continue his or her coverage and the coverage of his or her dependents, provided that the employee shall pay to his or her employer in advance that portion, if any, of the charges due from the employees to continue the coverage under his or her existing coverage.

6. A retired employee or surviving spouse who voluntarily discontinues coverage because of a return to covered public employment, may reenroll in the State Health Benefits Program upon termination of the covered public employment.

As amended, R.1973 d.8, effective January 4, 1973.

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

As amended, R.1979 d.261, effective July 3, 1979.

See: 11 N.J.R. 208(b), 11 N.J.R. 415(a).

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

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

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

Amended by R.1989 d.336, effective July 3, 1989.

See: 21 N.J.R. 886(b), 21 N.J.R. 1836(b).

Reenrollment provisions added at (c)6.

## 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 Termination; Basic Benefits

The Basic Benefits coverage of an employee, and an employee's dependents, may be continued after termination of coverage under this group for any reason except voluntary termination, on a direct remittance basis under Left Group Coverage, as provided in the Commission's Master Contract or Contract.

## 17:9-7.4 Voluntary termination

An employee may elect voluntarily to terminate his or her coverage or coverage for his or her dependents at any time, but termination of the employee's own coverage shall automatically terminate the coverage of his or her dependents. Such voluntary termination shall be effected by written notice thereof to the Health Benefits Bureau by use of the enrollment and authorization form. Termination notices for employees enrolled in an HMO will be sent, directly to the HMO by the employer.

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

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

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

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

Reference to female employees added.

## SUBCHAPTER 8. PRESCRIPTION DRUG PROGRAM

### Subchapter Historical Note

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

### 17:9-8.1 State Prescription Drug Program comparable to State Health Benefits Program

In accordance with the guidelines issued by the State Health Benefits Commission under terms of Chapter 12, Public Law 1975, and as those guidelines establish eligibility for coverage, the opportunity for an annual enrollment period, continuation of coverage during a leave of absence without pay, and circumstances concerning the change in, or the termination of, coverage on a basis identical to that of the State Health Benefit Program as administered by the Commission in accordance with the provisions of Chapter 49, Public Law 1961, as such apply to active State employees, the administration of the State Prescription Drug Program shall in all possible respects be identical to the State Health Benefits Program for such State employees. Any enrollment, application for a change in, or a termination of, coverage in the State Health Benefits Program shall be considered for a comparable result in the State Prescription Drug Program, except for the lack of rights of conversion. The annual enrollment period, or the effective date of coverage in the State Health Benefits Program for State employees shall likewise pertain to the State Prescription Drug Program.

Amended by R.1978 d.98, effective March 15, 1978.

See: 10 N.J.R. 40(a), 10 N.J.R. 175(c).

Recodified from 17:1-10.1 and amended by R.1993 d.268, effective August 2, 1993.

See: 25 N.J.R. 675(b), 25 N.J.R. 3506(b).

### Case Notes

Claim of ignorance as to time limit for applying for medical reimbursement was not a basis for excusing late claim. *Guerino v. Health Benefits Commission*, 93 N.J.A.R.2d (TYP) 226.

Member of state health benefits plan entitled to reimbursement of prescription drug expenses despite proof of loss filed beyond 90 day period. *Grosman v. State Health Benefits Commission*, 92 N.J.A.R.2d (TYP) 35.

### 17:9-8.2 Prescription drug cards and booklets

(a) All identification cards shall be issued by the carrier upon initial enrollment or change of coverage. Each issue shall reflect the bargaining unit in which the State employee participates. All cards and booklets will be distributed through the payroll and personnel officers. Requests for the general booklet shall be made to the Division.

(b) Applications for the replacement of cards will be accepted from those certifying a loss of their card, or in the case of divorce or separation, where coverage may be continued to a dependent.

Recodified from 17:1-10.2 and amended by R.1993 d.268, effective August 2, 1993.

See: 25 N.J.R. 675(b), 25 N.J.R. 3506(b).

### 17:9-8.3 Termination; effective date

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

(b) Eligibility shall be terminated as follows:

1. In the case of leave of absence without pay, 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; except that 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.

2. In the event that an employee's active full-time employment shall cease and employee shall become a "part-time" employee, such employee's coverage, and the coverage of such employee's dependents, shall be terminated.

3. An employee whose coverage terminated as a result of a change from full-time to part-time status cannot be reenrolled until he or she has reestablished his or her eligibility for coverage by serving the normal waiting period as prescribed for new enrollees. In no event will the waiting period include any part-time service rendered by the employee.

4. The coverage of an employee whose eligibility has ceased because of his or her resignation, temporary layoff, separation through a reduction in force, or any other reason, and the coverage of his or her dependents, shall be terminated.

5. An employee, who has an award pending, or who received an award of periodic benefits under Workers' Compensation, may continue his or her coverage and the coverage of his or her dependents, provided that the employee shall pay to his or her employer in advance that portion, if any, of the charges due from the employees to continue the coverage under his or her existing coverage.

6. Where the otherwise eligible employee elects a voluntary furlough, as authorized by P.L. 1993, c.297, coverage shall continue with the employer paying the costs as if the member were an active employee.

New Rule, R.1993 d.268, effective August 2, 1993.  
See: 25 N.J.R. 675(b), 25 N.J.R. 3506(b).  
Amended by R.1995 d.3, effective January 3, 1995.  
See: 26 N.J.R. 2202(a), 27 N.J.R. 128(a).

## SUBCHAPTER 9. DENTAL EXPENSE PROGRAM

### Subchapter Historical Note

Subchapter 9, Dental Expense Program, was formerly codified at N.J.A.C. 17:1-11 (Chapter 1) and was filed and became effective on March 15, 1978, as R.1978 d.99. See: 10 N.J.R. 38(b), 10 N.J.R. 175(d). Subchapter 9 was recodified by R.1993 d.268, effective August 2, 1993. See: 25 N.J.R. 675(b), 25 N.J.R. 3506(b).

### 17:9-9.1 State Dental Expense Program; comparable to State Health Benefits Program

(a) Under terms of Chapter 12, Public Law 1975, eligibility and effective dates of coverage, the advance premium payments, the opportunity for an annual enrollment period, continuation of coverage during a transfer or leave of absence without pay, and circumstances concerning the change in, or the termination of, coverage on a basis identical to that of the State Health Benefits Program as administered by the State Health Benefits Commission in accordance with the provisions of Chapter 49, Public Law 1961, as such applies to active State employees, the administration of the State Dental Expense Program shall in all possible respects be identical to the State Health Benefits Program for such State employees. As the program is voluntary and contributions equal to one half of the premium charge for employees and dependents are prescribed, separate applications will be required for enrollment and for a change in, or a termination of, coverage in the Dental Expense Program. Yet all other matters related to coverage in the State Health Benefits Program shall be considered for a comparable result in the State Dental Expense Program, except for:

1. Lack of rights of conversion;
2. Coverage continued during approved leave of absence without pay of not more than three months (six biweekly pay periods) provided the employee pays the entire premium in advance (employer and employee shares for employees and dependents);
3. Coverage is not continued in the event of death or retirement;
4. A different annual enrollment period; and
5. Employees enrolling at the inception of the plan and new employees enrolling before July 1, 1978 will not be able to voluntarily terminate the coverage until July 1,

1979, while all employees enrolled for coverage to begin in any subsequent year will be required to participate in the plan for a minimum 12-month period. (An employee may change the type of coverage if such results from a change in coverage status or dependency, such as marriage, divorce or separation, death of a spouse or dependent child, return from military leave, when there are no longer any minor children, spouse ceases to be an employee or upon the adoption or appointment of a guardian of dependent children and the application for such change would have to be made in accordance with the regulations governing such change in status or dependency; similarly, the termination date of coverage of the employee and his qualified dependents shall depend upon the termination of his employment or by reason of his ceasing to be in the classes of employees eligible for coverage. His eligibility shall cease because of his resignation, temporary lay-off, separation through a reduction in force, or for any other reason. The effective date of termination shall be the last day of coverage period for which premiums have been paid for the employee and his qualified dependents.)

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

Amended by R.1995 d.3, effective January 3, 1995.  
See: 26 N.J.R. 2202(a), 27 N.J.R. 128(a).

### 17:9-9.2 Dental expense cards and booklets

(a) Identification cards will be reissued periodically to assure the validity of coverage. All other cards will be issued by the carrier during the contract year upon the initial enrollment or change of coverage. All cards and booklets will be distributed through the payroll and personnel officers. Upon termination of employment or coverage, payroll and personnel officers shall make every effort to obtain a return of the identification card.

(b) Applications for the replacement of cards will be accepted from those certifying a loss of their card or, in the case of divorce or separation, where coverage may be continued to a qualified dependent.

### 17:9-9.3 Enrollment charges

Each eligible employee who enrolls for coverage shall be required to authorize the taking of deductions in order to pay one half of the premium charges for himself and his qualified dependents.

### 17:9-9.4 Enrollment forms

At a time each employee first becomes eligible for coverage, he may complete enrollment and authorization forms indicating his election to enroll for coverage on his own behalf and on behalf of his qualified dependents under one

of the options to be provided in the master contract. In the absence of any authorization for payroll deductions coverage cannot be extended.

#### 17:9-9.5 Annual enrollment period

Any employee who shall elect not to enroll for coverage for himself or for his qualified dependents at the time such employee or dependent first becomes eligible for coverage shall subsequently be permitted to enroll himself and his dependents only during the annual enrollment period, which is the month of May of each year with coverage effective for the first coverage period in October, except that there will be no such annual enrollment period in 1978, the first year in which the program is established.

#### 17:9-9.6 Waiting period

There shall be a two-month (four biweekly pay periods) waiting period before coverage can begin on behalf of employees who have applied for themselves and their qualified dependents. In addition to such two-month waiting period, there shall be an additional eight-month waiting period before participants will be eligible for orthodontic benefits. Credit for qualified State service immediately preceding their election to participate at the inception of the plan or during any annual enrollment period can be counted towards establishing the 10 months or more of continuous service required for orthodontics. Otherwise, all other benefits will be available and such participants will become eligible for orthodontics as soon as 10 months of continuous qualified State service has been accumulated.

#### 17:9-9.7 Covered expenses

While the master contract contains the specific provisions for services to be covered and those which are excluded, with the necessary limitations pertaining to different types of services, essentially the State Dental Expense Program will provide for the reimbursement of 80 percent of the usual, customary, and reasonable charges for diagnostic, prophylaxis, restorative, palliative, endodontic, oral surgical, and orthodontic procedures performed by licensed dentists (or dental hygienists), allowing for a \$25.00 annual deductible per eligible member with a \$75.00 maximum family deductible (three deductibles). Among other limitations, orthodontics is delimited to the correction of bite problems, caused by the malformation of tooth or bone structure, for covered persons who have not reached their 19th birthdate with a maximum of \$800.00, including charges for diagnosis and active and retention treatment.

#### 17:9-9.8 Premiums and coverage; 10-month employees

State employees hired as of September 1 under a 10-month contract shall have premiums deducted from the wages they receive in September to establish their coverage as of the beginning date of their employment. In the last month (June) of the employees' year of employment, premiums will be deducted to continue their coverage during the months of July and August provided their employment is to resume in September.

#### 17:9-9.9 (Reserved)

R.1980 d.63, effective February 5, 1980

See: 12 N.J.R. 52(d), 12 N.J.R. 163(a).

Amended by R.1980 d.487, effective November 5, 1980.

See: 12 N.J.R. 614(a), 12 N.J.R. 729(a).

Section was "Dependents; extension of coverage".