

17:9-2.8 Transfers

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

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

Recodified from N.J.A.C. 17:9-2.9 and amended by R.2003 d. 437, effective November 3, 2003.

See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).

Rewrote the section.

17:9-2.9 HMO; elections

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

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

1. Continue participation in their current HMO Plan; or
2. Transfer participation to one of the other plans available under the SHBP.

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

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

As amended, R.1976 d.124, eff. April 22, 1976.

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

As amended, R.1983 d.129, eff. May 2, 1983.

See: 15 N.J.R. 81(b), 15 N.J.R. 697(b).

Subsection (b) added.

Recodified from N.J.A.C. 17:9-2.10 and amended by R.2003 d. 437, effective November 3, 2003.

See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).

Substituted "Subscribers" for "Employees" throughout; in (b), rewrote 1 and 2 and deleted 3. Former N.J.A.C. 17:9-2.9, Transfers, recodified to N.J.A.C. 17:9-2.8.

Amended by R.2009 d.150, effective May 4, 2009.

See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).

Rewrote (b)2.

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

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

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

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

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

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

As amended, R.1979 d.159, eff. April 23, 1979.

See: 11 N.J.R. 94(d), 11 N.J.R. 304(c).

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

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

Reference to premiums changed to charges.

Recodified from N.J.A.C. 17:9-2.11 and amended by R.2003 d. 437, effective November 3, 2003.

See: 34 N.J.R. 2587(a), 35 N.J.R. 5149(a).

Rewrote (a) and (b); in (c), deleted "up to a period of three months" following "it may be granted"; Former N.J.A.C. 17:9-2.10, HMO; elections, recodified to N.J.A.C. 17:9-2.9.

Amended by R.2005 d.187, effective June 20, 2005.

See: 37 N.J.R. 397(a), 37 N.J.R. 2212(b).

In (b), inserted "or surviving eligible domestic partners" preceding "the eligible survivor".

Amended by R.2009 d.150, effective May 4, 2009.

See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).

In (b), inserted "or civil union"; and in (c), inserted "up to one year".

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

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

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

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

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

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

Deleted "being able to satisfy the normal activities test required by the contract". Inserted "not be deferred ... N.J.A.C. 17:9-2.8(b)".

Amended by R.1988 d.469, eff. October 3, 1988.
See: 20 N.J.R. 1526(b), 20 N.J.R. 2466(e).

Added "deductibles and copayments".
Recodified from N.J.A.C. 17:9-2.12 and amended by R.2003 d. 437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).

Rewrote the section. Former N.J.A.C. 17:9-2.11, Coverage for survivors, recodified to N.J.A.C. 17:9-2.10.
Amended by R.2009 d.150, effective May 4, 2009.
See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).

Section was "Traditional Plan major medical and out-of-network NJ PLUS; eligible charges at enrollment (local employees)". Substituted "DIRECT" for "PLUS" throughout; in (a), deleted "Traditional Plan major medical coverage or" preceding "out-of-network"; in (b), deleted "Traditional Plan major medical or" preceding "out-of-network"; and in (c), deleted "the Traditional Plan major medical or" preceding "out-of-network" and "and no charges will be considered that would have been paid by the basic plan, had the employee had such coverage" following "contract".

17:9-2.12 Extension of coverage charges

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

1. The charges would have been considered eligible charges had the extension not terminated;
2. The coverage under the extension would have not otherwise terminated.

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

Recodified from N.J.A.C. 17:9-2.13 and amended by R.2003 d. 437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).

Former N.J.A.C. 17:9-2.12, Major Medical; eligible charges at enrollment (local employees), recodified to N.J.A.C. 17:9-2.11.

17:9-2.13 Duplication of benefits

If the State or local employer adopts separate plans for all employees or for some portion of covered employees, largely duplicating benefits provided under the SHBP medical plan, such services or benefits for the participants of such separate

plans will no longer be considered eligible for reimbursement under the employee's medical plan.

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

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

As amended, R.1980 d.300, eff. July 1, 1980.

See: 12 N.J.R. 216(b), 12 N.J.R. 497(b).

Recodified from N.J.A.C. 17:9-2.15 and amended by R.2003 d. 437, effective November 3, 2003.

See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).

In (a), deleted gender references and references to the Major Medical Contract in the introductory paragraph. Former N.J.A.C. 17:9-2.13, Major Medical; extension of coverage charges, recodified to N.J.A.C. 17:9-2.12.

17:9-2.14 Policy provisions adoption

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

R.1981 d.138, effective June 4, 1981.

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

Recodified from N.J.A.C. 17:9-2.16 and amended by R.2003 d. 437, effective November 3, 2003.

See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).

Substituted "health and dental plans" for "carriers, the health maintenance organizations". Former 17:9-2.14, Effective date, maternity benefits, repealed.

Amended by R.2009 d.150, effective May 4, 2009.

See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).

Deleted "State Health Benefits" preceding "Commission" twice, and inserted " , prescription drug", a comma following the second occurrence of "Commission", and the last sentence.

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

Case Notes

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

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.

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

New Rule, R.1998 d.265, effective June 1, 1998.

See: 30 N.J.R. 803(a), 30 N.J.R. 2070(a).

Amended by R.2000 d.298, effective July 17, 2000.

See: 32 N.J.R. 1322(a), 32 N.J.R. 2601(b).

In (b), inserted "but before July 1, 2000," in the introductory paragraph; in (c), substituted "after July 1, 1997, but before July 1, 2000 or retire on a disability retirement after July 1, 1997 but before August 1, 2000" for "or retire on a disability retirement after July 1, 1997" following "system"; and added (e).

Amended by R.2003 d.184, effective May 5, 2003.

See: 35 N.J.R. 86(a), 35 N.J.R. 1924(a).

Rewrote (a); in (e)2, deleted "the State of New Jersey Managed Care/Point of Service Plan," following "NJ PLUS"; added (f).

Amended by R.2005 d.187, effective June 20, 2005.

See: 37 N.J.R. 397(a), 37 N.J.R. 2212(b).

In (a), inserted "or eligible domestic partner" following "the employee's spouse" in the first sentence; added (g).

Amended by R.2009 d.150, effective May 4, 2009.

See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).

Substituted "DIRECT15" for "PLUS" throughout; in (a), deleted "domestic" preceding "partner" and "Traditional Plan" preceding the first occurrence of "coverage"; in the introductory paragraph of (b), (b)1, (c), the introductory paragraph of (e), and (e)1, substituted "NJ DIRECT10" for "Traditional Plan"; in the introductory paragraph of (b), inserted "using a base salary as of the first pay period of the calendar year in which retirement occurred, as follows"; in (c), inserted a comma following "shall" and "upon retirement"; in the introductory paragraph of (e), inserted "but before June 20, 2007" and "but on or before July 1, 2007"; in (e)1, deleted "and" from the end; in (e)2, substituted "; and" for a period at the end; and added (e)3.

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

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

1. Is a retiree from:

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

ii. The Consolidated Police and Firemen's Pensions Fund (N.J.S.A. 43:16-1 et seq.), hereinafter referred to as 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 SHBP in accordance with the laws and rules governing the program, regardless of whether the retiree's employer participated in the program, and for State payment of an amount of the premium or periodic charges for the category of coverage elected by the qualified retiree equal to 80 percent of the premium or periodic charges for that category of coverage under the State-managed care plan or health maintenance organization, which provides services in the 21 counties of the State and the lower premium or periodic charges.

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

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

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

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

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

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

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

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

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

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

(f) A qualified retiree who waives coverage at retirement, or at a later date, due to health benefit coverage (active or retired) through an employer as a dependent shall be eligible for the benefits after termination of dependent coverage if the retiree applies to the SHBP for the benefits within 60 days

after the effective date of termination of dependent coverage. A certificate of continued coverage or employer letter certifying when coverage terminated must accompany the retiree application.

New Rule, R.1999 d.373, effective November 1, 1999.

See: 31 N.J.R. 2300(b), 31 N.J.R. 3524(b).

Amended by R.2000 d.495, effective December 18, 2000.

See: 32 N.J.R. 3387(a), 32 N.J.R. 4451(a).

In (a)1, rewrote iii.

Amended by R.2003 d.437, effective November 3, 2003.

See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).

Rewrote (c); added (e).

Amended by R.2005 d.187, effective June 20, 2005.

See: 37 N.J.R. 397(a), 37 N.J.R. 2212(b).

In (d), added the last sentence; in (e), inserted "or dependent" following "an employee" in the second sentence and inserted "or eligible domestic partner" preceding "surviving spouse" throughout; added (f).

Amended by R.2009 d.150, effective May 4, 2009.

See: 41 N.J.R. 101(a), 41 N.J.R. 2037(a).

Section was "Eligibility for State payment of retiree coverage under P.L. 1997, c.330". In (a)liii, substituted "c. 257" for "c.257", "PRFS-covered" for "PRFS covered" and "c. 204" for "c.204"; in (b), substituted "c. 330" for "c.330", "c. 49" for "c.49" and "State-managed" for "State managed", and deleted "State Health Benefits Program (" preceding and a closing parenthesis following "SHBP"; in the introductory paragraph of (c), substituted "c. 330" for "c.330"; in (c)1, substituted "SHBP" for "State Health Benefits Program", "c. 49" for "c.49" and "c. 8" for "c.8"; in (c)2, substituted "c. 125" for "c.125"; and in (e), deleted "domestic" preceding "partner" throughout, inserted a comma following "et seq." and substituted "SHBP" for "State Health Benefits Program".

17:9-6.10 Retiree prescription drug plan

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

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

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

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

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

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