State of New Jersey
DIVISION OF PENSIONS AND BENEFITS
PO Box 295 • Trenton, NJ 08625-0295

October 2006

TO THE HONORABLE
JON S. CORZINE
GOVERNOR of the STATE OF NEW JERSEY

Dear Governor Corzine:

As Secretary of the New Jersey State Health Benefits Commission and Director of the Division of Pensions and Benefits, I am pleased to present the fiscal year 2006 State Health Benefits Program Annual Report in accordance with the provisions of N.J.S.A. 52:14-17.27.

We have had a year that has seen many positive changes to our health programs as we continue to implement new, innovative, and cost effective benefit designs. In fiscal year 2006:

- Our health benefit cost trends have been decreasing for the NJ PLUS plan due to five new Disease Management protocols added to the Point of Service plan benefit design. The Disease Management initiative also had a significant positive impact for retirees who have a higher frequency of the type of claims which can benefit from Disease Management.
- We have implemented new cost containment measures in Employee/Retiree Prescription Drug Plans that have decreased cost and increased our rebates.

It is the goal of the Division of Pensions and Benefits to continue to pursue new and innovative health care programs and concepts that will enhance the care to our members while continuing to contain health costs for all concerned.

Respectfully submitted,

FREDERICK J. BEAVER
Secretary

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NEW JERSEY STATE HEALTH BENEFITS PROGRAM

Mission and Vision

Mission

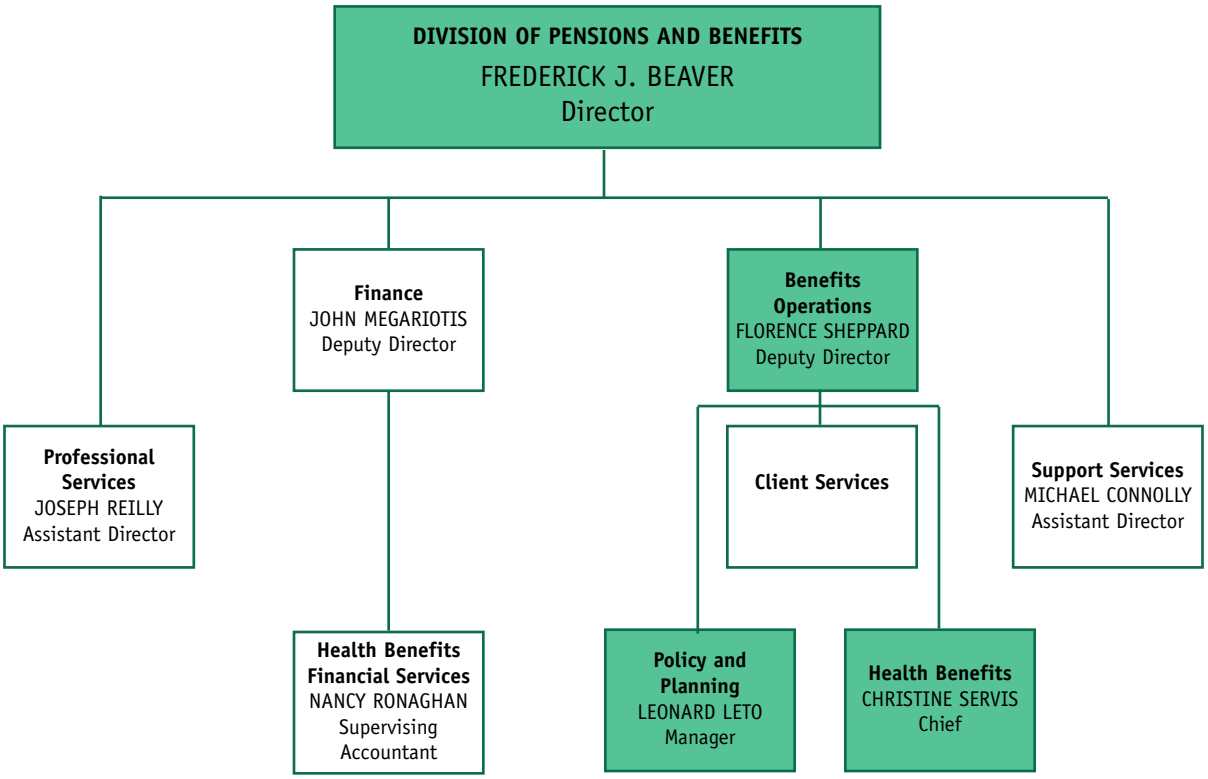
The State Health Benefits Program is committed to a standard of excellence that delivers quality health care in an efficient and cost effective manner.

Vision

To be proactive in establishing the standard for top quality benefits by focusing on innovative approaches and a commitment to member satisfaction.

STATE HEALTH BENEFITS PROGRAM AND RELATED SERVICES

Organization Chart as of June 30, 2006



NEW JERSEY STATE HEALTH BENEFITS PROGRAM

Overview

The State Health Benefits Program (SHBP) offers a variety of health plans for the more than 800,000 active and retired New Jersey public sector employees and their dependents. The SHBP consists of two distinct groups - the State Group and the Local Employer Group that includes entities such as boards of education, municipalities, counties, etc. The education and local municipality groups are rated separately since their overall experience differs.

The responsibility for the operations of the SHBP resides with the Director of the Division of Pensions and Benefits. The Division is part of the State's Department of the Treasury. The policy-making body of the SHBP is the State Health Benefits Commission (SHBC). The SHBC includes the State Treasurer as the chairperson, the Commissioner of the Department of Banking and Insurance, the Commissioner of the Department of Personnel, a State employee representative chosen by the Public Employees' Committee of the AFL-CIO, and a representative chosen by the New Jersey Education Association (NJEA), or their designated representatives. The Director of the Division of Pensions and Benefits is the Secretary to the SHBC. All decisions made by the Commission are a matter of public record.

The Division of Pensions and Benefits, specifically the Health Benefits Bureau and the Bureau of Policy and Planning, is responsible for the daily administrative activities of the SHBP under the direction of a Deputy Director.

Bureau of Health Benefits

The Health Benefits Bureau is responsible for all SHBP enrollment activities encompassing 7 medical plans, 12 dental plans, and a prescription drug plan. In addition, the Bureau is responsible for the administration of benefits under the federal COBRA law.

Bureau of Policy and Planning

The Bureau of Policy and Planning analyzes and makes recommendations concerning all current and proposed health benefits programs. The Bureau is also responsible for contract renewals, requests for proposals, State Health Benefits Commission business, and plan vendor compliance.

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

History

The State Health Benefits Program was established by Chapter 49, P.L. 1961 to provide traditional indemnity benefits for State employees and their dependents. Chapter 125, P.L. 1964 extended the program to include employees of local government at the option of each public employer.

Chapter 337 of the Public Laws of 1973 (C.26:2J-2) authorized the establishment of Health Maintenance Organizations to be offered to both State and local employers. The first HMO enrollment took place in 1976.

In 1989, the State Health Benefits Commission introduced a point-of-service plan known as NJ PLUS.

A carved-out Prescription Drug Program was initiated as a result of union negotiations for certain State employees effective December 1, 1974. The passage of Chapter 41, P.L. 1976 extended this coverage to all eligible State employees. The State Health Benefits Commission offered the program to local employers that participated in the SHBP on July 1, 1993.

The State Dental Program was established February 1, 1978 for State employees only. Initially only one plan was offered: a traditional indemnity plan known as the New Jersey State Dental Expense Benefits Program. The Program expanded in June 1984 to include Dental Provider Organizations (DPOs). In 2005, all eligible employees of the State and participating local government employers who adopted a resolution to provide dental benefits under the SHBP may enroll for dental coverage. The Retiree Dental Expense Plan was established January 1, 2005 as a retiree pay-all plan.

The Traditional Plan, NJ PLUS and the Employee Prescription Drug Program, as well as all HMOs, are self-insured. The dental indemnity plan is also self-insured, with administrative services provided by Aetna. All participating Dental Provider Organizations offered are on an insured basis.

The Statutes governing the SHBP can be found in the New Jersey Statutes Annotated, Title 52, Chapter 14, Article 3D. Rules governing the operation and administration of the program may be found in Title 17, Chapter 9 of the New Jersey Administrative Code.

Health Plans Offered

NJ PLUS

A point-of-service plan that utilizes a gatekeeper approach, offers in-network services and the health promotion features of managed care plans. The plan also offers out-of-network services with a full choice of physicians and services, subject to deductibles, coinsurance and reasonable and customary allowances similar to an indemnity plan.

Traditional Plan

An indemnity plan that allows free choice of medical providers and facilities. Reimbursement is subject to reasonable and customary allowances, deductibles and coinsurance. The plan does not provide coverage for wellness services such as routine checkups and screening tests, except where specifically directed by legislation.

Health Maintenance Organizations (HMOs)

Choices of multiple programs offering comprehensive coverage where employees choose a primary care physician from a closed network of participating providers to manage all care provided. Most HMOs cover the entire State and adjacent counties in neighboring states where licensed. For Medicare eligible retirees, all State participating HMOs coordinate their benefits with Medicare. Several HMOs now offer coverage in the following states: Pennsylvania, Connecticut, Delaware, Arizona, South Carolina, and Washington, D.C.; parts of California, New York, Florida, Illinois, Indiana, Maryland, Massachusetts, Nevada, New Hampshire, North Carolina, Ohio, Texas, Virginia, Georgia, and West Virginia.

Dental Program

State employees and employees of participating employers may choose a traditional indemnity plan called the Dental Expense Plan or prepaid dental HMOs, called Dental Provider Organizations. Dental coverage is optional. State employees who opt for coverage pay 50% of the overall cost through payroll deductions, local participating employees pay up to 50% of the overall cost. In 2005, Dental coverage was made available to State retirees and local retirees. Retirees pay 100% of the overall dental cost.

Prescription Drug Program

Employee Prescription Drug Plan

The Employee Prescription Drug Plan is offered to active State employees and their eligible dependents as a separate drug plan. Local employers may also elect to provide the SHBP Employee Prescription Drug Plan to their employees as a separate prescription drug benefit.

The Employee Prescription Drug Plan is currently administered by Caremark through Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ).

A mail order program is also available.

Retiree Prescription Drug Plan

Effective 2002, all prescription drug plans available to retirees became three-tiered prescription drug plans. Mail order service was also included in all retiree prescription drug plans.

Plan Changes

Administrative Change

The Fortis DPO plan was purchased by Assurant Employee Benefits and renamed Assurant DPO.

HIPAA Requirements

The State Health Benefits Commission has filed for exemption from the HIPAA mental health parity requirement with the federal Health Care Financing Administration for calendar year 2005. As a result, the maximum annual and lifetime dollar limits for mental health benefits under the Traditional Plan and NJ PLUS have not changed.

2006 Significant Legislation

Chapter 135, P.L. 2005

This law provides that an affiliate of a majority representative of State employees for collective negotiation purposes, which affiliate represents State employees, may obtain coverage in the State Health Benefits Program (SHBP) for its elected officers and employees and their dependents. As used in the law, the phrase "an affiliate of a majority representative of State employees" means a local union affiliate that has some employees who are engaged in the day-to-day representation of State employees, and does not mean a local union affiliate's parent or international union.

Each affiliate electing to participate in SHBP will remit the premium rates or periodic charges to the program, as such rates or charges are determined for local government employees and applicable to the coverage provided.

This law requires that on its effective date the Division of Pensions and Benefits in the Department of the Treasury must seek a determination letter from the federal Department of Labor confirming the status of the State Health Benefits Program as a qualified and exempt governmental plan under Title I of the federal Employee Retirement Income Security Act of 1974 (ERISA). In the event the division receives a determination letter from the federal Department of Labor stating that the law as embodied in this law changes the status of the State Health Benefits Program so that it is no longer a qualified and exempt governmental plan under Title I of ERISA, the law would be void and expire immediately and no employees of an affiliate of a majority representative of State employees for collective negotiation purposes would be permitted to newly enroll or continue to participate in the State Health Benefits Program.

This law took effect on July 7, 2005, with union SHBP participation to begin 120 days hence.

Chapter 341, P.L. 2005

This law amends N.J.S.A. 52:14-17.28 to provide that all law enforcement officers employed by the State for whom there is a majority representative for collective negotiations purposes may not be eligible for coverage under the Traditional Plan within the State Health Benefits Program (SHBP). Coverage under the SHBP Traditional Plan may be limited or discontinued pursuant to a binding collective negotiations agreement or pursuant to the application by the State Health Benefits Commission, in its sole discretion, of the terms of any collective negotiations agreement binding on the State to non-aligned State employees.

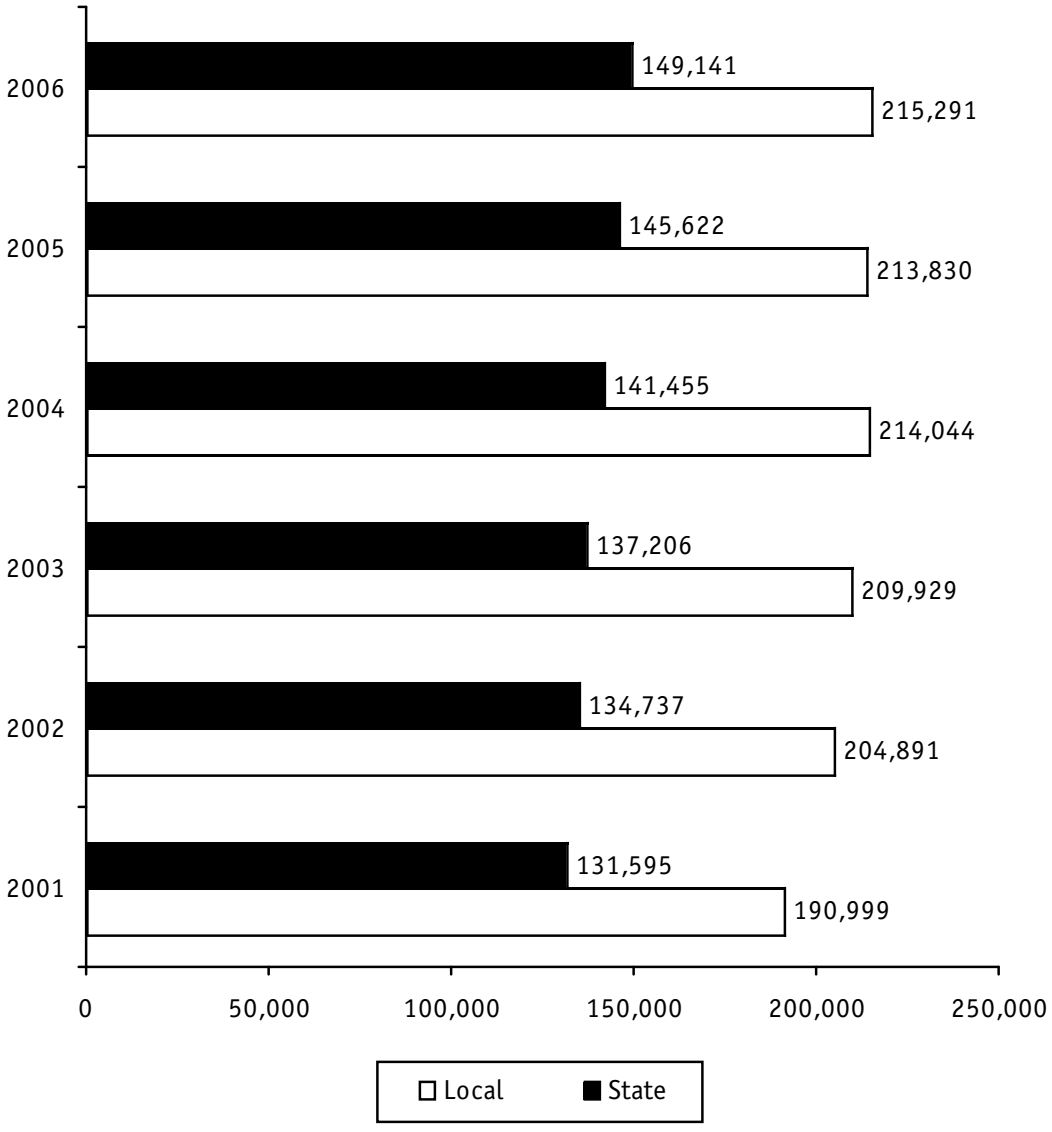
In addition, it amends N.J.S.A. 52:14-17.32 to require that, for law enforcement officers employed by the State for whom there is a majority representative for collective negotiation purposes and for nonaligned sworn

2006 Significant Legislation, Continued

members of the Division of the State police who retire after July 1, 2005, the coverage options available to such employees in retirement will be limited to those options that were available to the employee on the employee's last day of employment.

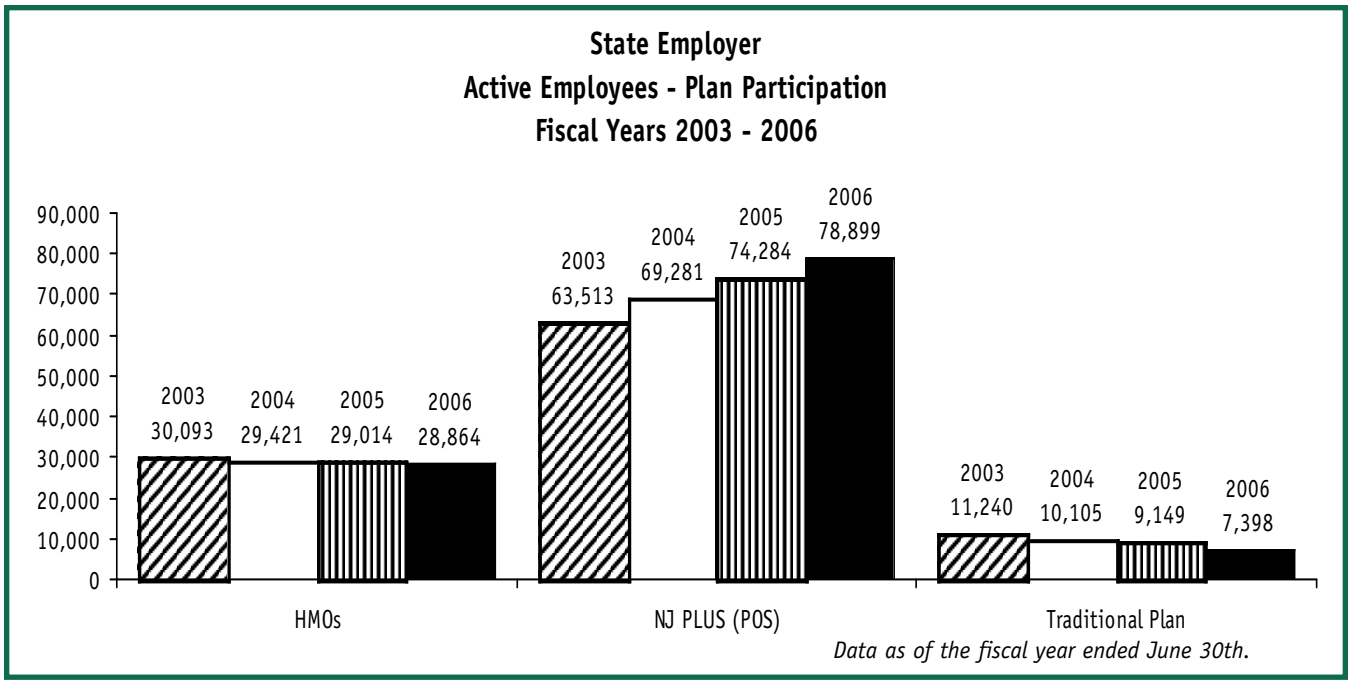
This law took effect on January 12, 2006.

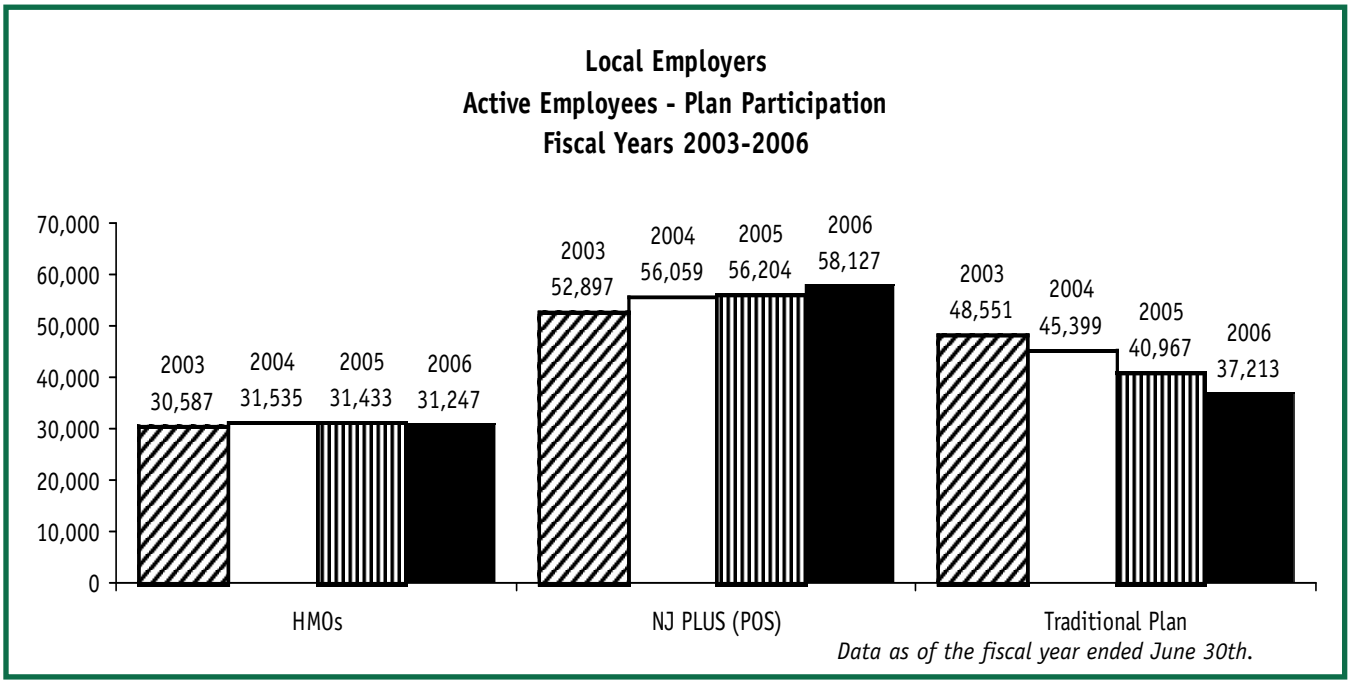
SHBP Membership



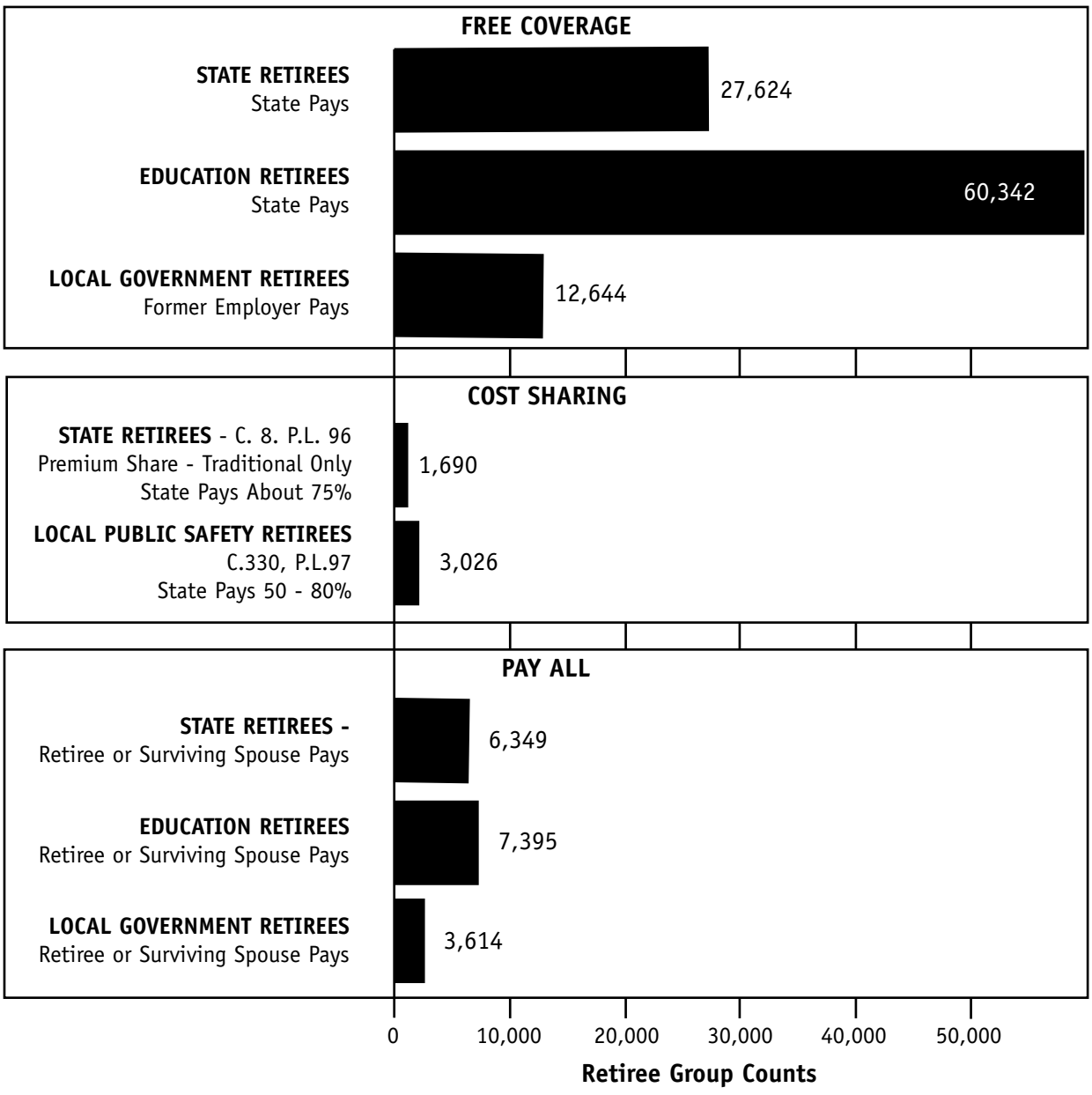
Data as of the fiscal year ended June 30th.
Data reflects employee, retiree, and COBRA contracts.

SHBP Membership





SHBP Retirees - Who pays for Health Benefits Coverage?



Data as of the fiscal year ended June 30th.

SHBP Enrollment — State Employer Group

As of June 30, 2006

EMPLOYEES

PLAN NAME	EMPLOYEES	AS A % OF EMPLOYEE ENROLLMENT	DEPENDENTS OF EMPLOYEES	EMPLOYEES AND DEPENDENTS
NJ PLUS	78,899	68.52%	113,797	192,696
Traditional	7,398	6.42%	6,635	14,033
Aetna, Inc.	20,576	17.87%	33,622	54,198
Cigna	2,571	2.23%	3,845	6,416
Oxford	2,190	1.90%	3,562	5,752
Amerihealth	1,500	1.30%	2,354	3,854
Healthnet	2,027	1.76%	3,112	5,139
TOTAL	**115,161**	**100.00%**	**166,927**	**282,088**

RETIREES

PLAN NAME	RETIREES	AS A % OF RETIREE ENROLLMENT	DEPENDENTS OF RETIREES	RETIREES AND DEPENDENTS
NJ PLUS	9,448	27.80%	7,619	17,067
Traditional	17,861	52.56%	9,685	27,546
Aetna, Inc.	4,929	14.51%	4,026	8,955
Cigna	814	2.40%	718	1,532
Oxford	318	0.94%	211	529
Amerihealth	280	0.82%	237	517
Healthnet	330	0.97%	239	569
TOTAL	**33,980**	**100.00%**	**22,735**	**56,715**

BOTH EMPLOYEES AND RETIREES

PLAN NAME	EMPLOYEES AND RETIREES	DEPENDENTS OF EMPLOYEES AND RETIREES	TOTAL	AS A % OF ALL STATE ENROLLMENT (TOTAL LIVES)
NJ PLUS	88,347	121,416	209,763	61.92%
Traditional	25,259	16,320	41,579	12.27%
Aetna, Inc.	25,505	37,648	63,153	18.64%
Cigna	3,385	4,563	7,948	2.35%
Oxford	2,508	3,773	6,281	1.85%
Amerihealth	1,780	2,591	4,371	1.29%
Healthnet	2,357	3,351	5,708	1.68%
TOTAL	**149,141**	**189,662**	**338,803**	**100.00%**

SHBP Enrollment — Local Employer Group — Education

As of June 30, 2006

EMPLOYEES

PLAN NAME	EMPLOYEES	AS A % OF EMPLOYEE ENROLLMENT	DEPENDENTS OF EMPLOYEES	EMPLOYEES AND DEPENDENTS
NJ PLUS	35,050	44.34%	53,287	88,337
Traditional	25,762	32.59%	31,475	57,237
Aetna, Inc.	10,312	13.04%	15,890	26,202
Cigna	2,199	2.78%	3,622	5,821
Oxford	2,693	3.41%	4,497	7,190
Amerihealth	1,148	1.45%	1,934	3,082
Healthnet	1,887	2.39%	3,019	4,906
TOTAL	**79,051**	**100.00%**	**113,724**	**192,775**

RETIREES

PLAN NAME	RETIREES	AS A % OF RETIREE ENROLLMENT	DEPENDENTS OF RETIREES	RETIREES AND DEPENDENTS
NJ PLUS	10,312	14.86%	8,108	18,420
Traditional	53,287	76.78%	32,162	85,449
Aetna, Inc.	4,140	5.96%	3,104	7,244
Cigna	814	1.17%	705	1,519
Oxford	198	0.29%	103	301
Amerihealth	480	0.69%	422	902
Healthnet	176	0.25%	115	291
TOTAL	**69,407**	**100.00%**	**44,719**	**114,126**

BOTH EMPLOYEES AND RETIREES

PLAN NAME	EMPLOYEES AND RETIREES	DEPENDENTS OF EMPLOYEES AND RETIREES	TOTAL	AS A % OF ALL ENROLLMENT (TOTAL LIVES)
NJ PLUS	45,362	61,395	106,757	34.79%
Traditional	79,049	63,637	142,686	46.49%
Aetna, Inc.	14,452	18,994	33,446	10.90%
Cigna	3,013	4,327	7,340	2.39%
Oxford	2,891	4,600	7,491	2.44%
Amerihealth	1,628	2,356	3,984	1.30%
Healthnet	2,063	3,134	5,197	1.69%
TOTAL	**148,458**	**158,443**	**306,901**	**100.00%**

SHBP Enrollment — Local Employer Group — Government Employers

As of June 30, 2006

EMPLOYEES

PLAN NAME	EMPLOYEES	AS A % OF EMPLOYEE ENROLLMENT	DEPENDENTS OF EMPLOYEES	EMPLOYEES AND DEPENDENTS
NJ PLUS	23,077	48.55%	38,139	61,216
Traditional	11,451	24.08%	15,576	27,027
Aetna, Inc.	7,636	16.06%	12,992	20,628
Cigna	1,396	2.94%	2,642	4,038
Oxford	1,102	2.32%	2,245	3,347
Amerihealth	1,006	2.12%	1,799	2,805
Healthnet	1,868	3.93%	3,367	5,235
TOTAL	**47,536**	**100.00%**	**76,760**	**124,296**

RETIREES

PLAN NAME	RETIREES	AS A % OF RETIREE ENROLLMENT	DEPENDENTS OF RETIREES	RETIREES AND DEPENDENTS
NJ PLUS	3,777	19.58%	3,395	7,172
Traditional	12,339	63.94%	7,826	20,165
Aetna, Inc.	2,005	10.39%	2,338	4,343
Cigna	435	2.25%	512	947
Oxford	326	1.69%	393	719
Amerihealth	184	0.95%	189	373
Healthnet	231	1.20%	267	498
TOTAL	**19,297**	**100.00%**	**14,920**	**34,217**

BOTH EMPLOYEES AND RETIREES

PLAN NAME	EMPLOYEES AND RETIREES	DEPENDENTS OF EMPLOYEES AND RETIREES	TOTAL	AS A % OF ALL ENROLLMENT (TOTAL LIVES)
NJ PLUS	26,854	41,534	68,388	43.14%
Traditional	23,790	23,402	47,192	29.78%
Aetna, Inc.	9,641	15,330	24,971	15.75%
Cigna	1,831	3,154	4,985	3.14%
Oxford	1,428	2,638	4,066	2.57%
Amerihealth	1,190	1,988	3,178	2.00%
Healthnet	2,099	3,634	5,733	3.62%
TOTAL	**66,833**	**91,680**	**158,513**	**100.00%**

SHBP Enrollment by State and Local Employer Groups

As of June 30, 2006

EMPLOYEES

PLAN NAME	EMPLOYEES	AS A % OF EMPLOYEE ENROLLMENT	DEPENDENTS OF EMPLOYEES	EMPLOYEES AND DEPENDENTS
NJ PLUS	137,026	56.68%	205,223	342,249
Traditional	44,611	18.45%	53,686	98,297
Aetna, Inc.	38,524	15.94%	62,504	101,028
Cigna	6,166	2.55%	10,109	16,275
Oxford	5,985	2.48%	10,304	16,289
Amerihealth	3,654	1.51%	6,087	9,741
Healthnet	5,782	2.39%	9,498	15,280
TOTAL	**241,748**	**100.00%**	**357,411**	**599,159**

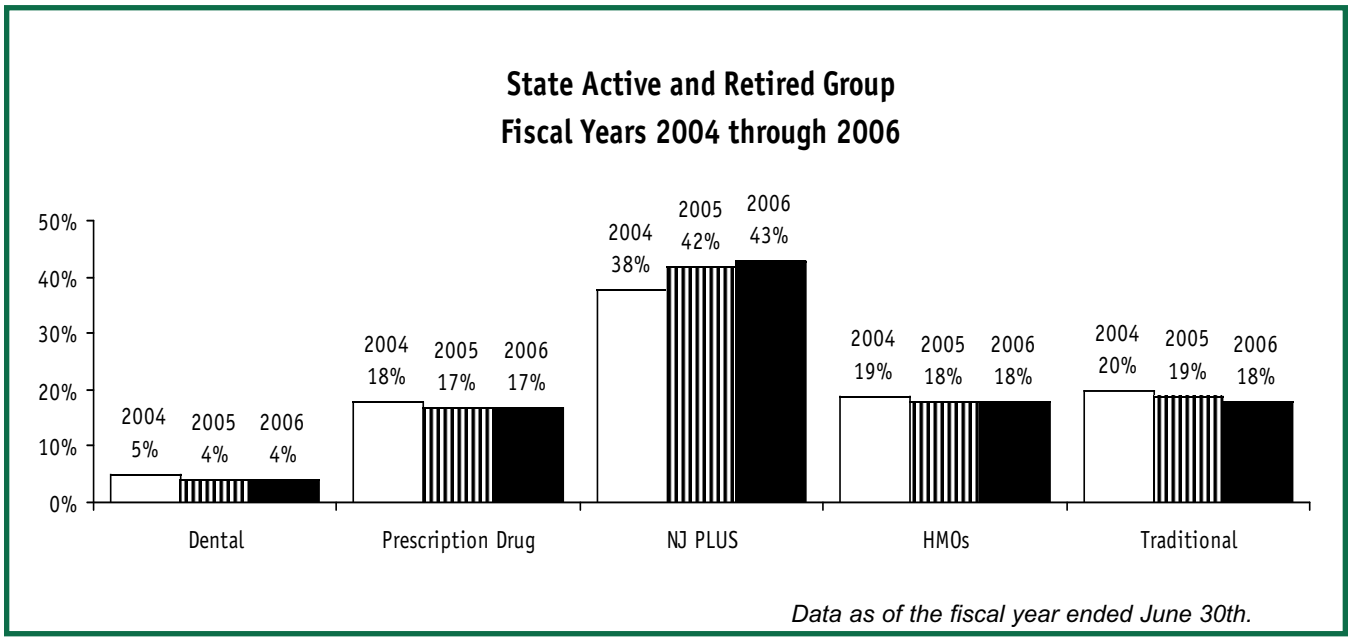
RETIREES

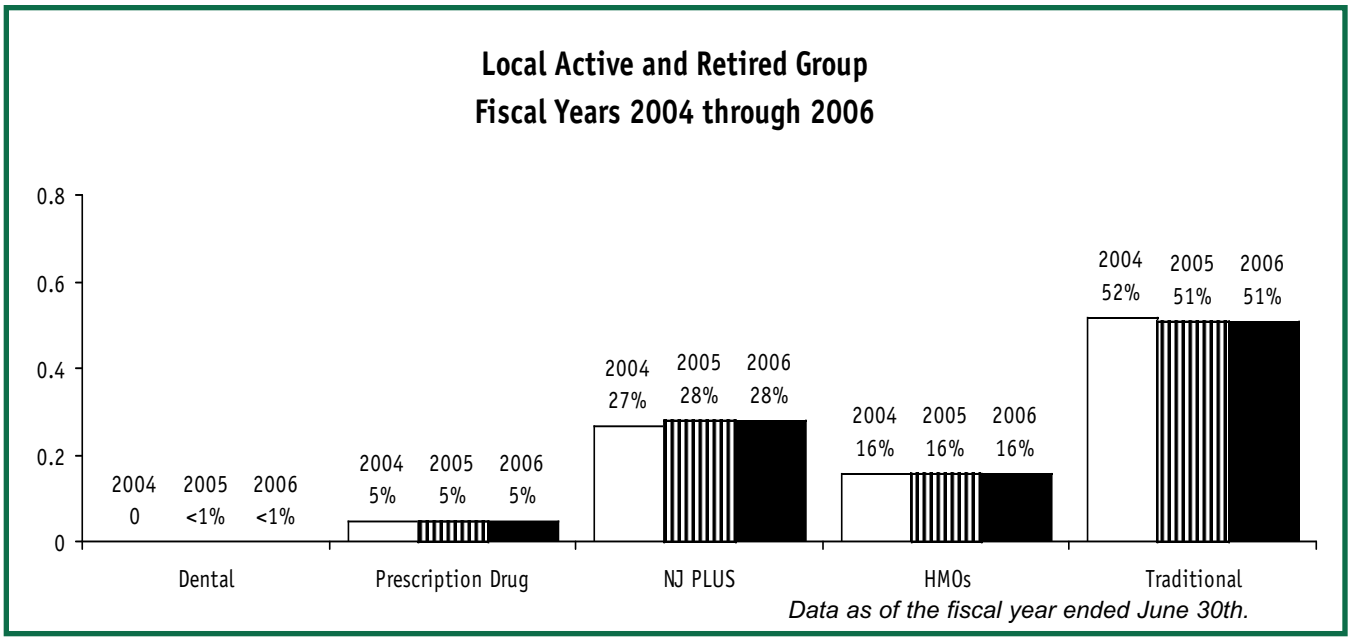
PLAN NAME	RETIREES	AS A % OF RETIREE ENROLLMENT	DEPENDENTS OF RETIREES	RETIREES AND DEPENDENTS
NJ PLUS	23,537	19.19%	19,122	42,659
Traditional	83,487	68.05%	49,673	133,160
Aetna, Inc.	11,074	9.03%	9,468	20,542
Cigna	2,063	1.68%	1,935	3,998
Oxford	842	0.68%	707	1,549
Amerihealth	944	0.77%	848	1,792
Healthnet	737	0.60%	621	1,358
TOTAL	**122,684**	**100.00%**	**82,374**	**205,058**

BOTH EMPLOYEES AND RETIREES

PLAN NAME	EMPLOYEES AND RETIREES	DEPENDENTS OF EMPLOYEES AND RETIREES	TOTAL	AS A % OF ALL SHBP ENROLLMENT (TOTAL LIVES)
NJ PLUS	160,563	224,345	384,908	47.86%
Traditional	128,098	103,359	231,457	28.78%
Aetna, Inc.	49,598	71,972	121,570	15.12%
Cigna	8,229	12,044	20,273	2.52%
Oxford	6,827	11,011	17,838	2.22%
Amerihealth	4,598	6,935	11,533	1.43%
Healthnet	6,519	10,119	16,638	2.07%
TOTAL	**364,432**	**439,785**	**804,217**	**100.00%**

Percentage of Health Care Premium Dollars Required for State Employer Group and Local Employer Group Plan Coverages





SHBP Local Participation 1996 - 2006

	COUNTIES	SCHOOL DISTRICTS	MUNICI-PALITIES	OTHERS*	CHARTER SCHOOLS**	SUB TOTAL	SUB GROUPS***	TOTAL	LOCAL EMPLOYEES RETIREES
JUL 1996	4	256	243	248		751	19	770	168,312
JAN 1997	3	206	229	247		685	17	702	
JUL 1997	3	218	224	250		695	21	716	134,374
JAN 1998	3	221	225	250	7	706	21	727	
JUL 1998	3	236	228	250	9	726	20	746	149,620
JAN 1999	4	245	227	250	9	735	22	757	
JUL 1999	4	280	230	253	9	776	23	799	162,910
JAN 2000	4	278	236	257	20	795	25	820	
JUL 2000	4	293	246	254	22	819	29	848	176,127
JAN 2001	4	295	254	267	23	843	35	878	
JUL 2001	4	307	267	268	23	869	37	906	190,999
JAN 2002	4	310	279	268	24	885	38	923	
JUL 2002	5	312	293	274	23	907	37	944	204,891
JAN 2003	5	314	300	267	22	908	35	943	
JUL 2003	5	311	308	274	22	920	33	953	209,929
JAN 2004	6	309	310	282	22	929	32	961	
JUL 2004	5	302	311	286	23	927	49	976	214,044
JAN 2005	5	293	314	290	25	927	49	976	
JUL 2005	5	290	311	292	23	921	47	968	213,830
JAN 2006	5	284	310	295	23	917	47	964	
JUL 2006	5	269	310	297	23	904	47	951	215,291

* Others category includes agencies such as authorities, commissions, state autonomous agencies, etc.

** A charter school is a public school open to all students, on a space-available basis, that operates independently of the district board of education under a charter granted by the Commissioner.

*** Subgroups may be a county, a municipality, or a school district and each one is linked to another SHBP employer. Subgroups are developed when an employer has a need to particularize a group of employees for billing purposes.

SHBP Participation by Dental Plans as of June 30, 2006

PLAN NAME	ESTIMATED STATE EMPLOYEE CONTRACTS	ESTIMATED LOCAL EMPLOYEE CONTRACTS	TOTAL CONTRACTS	AS A % OF EMPLOYEE ENROLLMENT
DENTAL PROVIDER ORGANIZATIONS				
International HealthCare	3,986	5	3,991	3.81%
Atlantic Southern	6,058	42	6,100	5.82%
Assurant	2,616	8	2,624	2.51%
Flagship Health	2,413	10	2,423	2.31%
Community Dental	1,749	6	1,755	1.68%
Horizon Healthcare Dental	6,296	45	6,341	6.05%
Aetna DMO	13,959	149	14,108	13.47%
Group Dental	320	2	322	0.31%
Dental Group of New Jersey	115	1	116	0.11%
Cigna Dental Health	7,307	25	7,332	7.0%
Subtotals	**44,819**	**293**	**45,112**	**43.0%**
Dental Expense Plan	58,834	803	59,637	57.0%
Total Active Contracts	**103,653**	**1,096**	**104,749**	**100.00%**
Total Retired Contracts	**9,943**	**27,864**	**37,807**	
As a % of Retired Enrollment	**26.3**	**73.7**		
Total Active/Retired Contracts			**142,556**	

Columns may not total 100% due to rounding.

Distribution of Prescription Drug (Rx) Coverage within Local Employer Group Active Employee Population

ALL LOCAL SHBP EMPLOYERS				
	Employers	Employees Covered	As a % of all Local Employers	As a % of all Local Employees
Employers with SHBP Employee RX Plan	344	34,863	37%	29%
Employers Providing Rx thru SHBP Medical Plans*	430	32,254	46%	27%
Employers with Private Rx Plan	152	53,551	17%	44%
Total	926	120,668	100%	100%

The SHBP provides Rx coverage in some form to 83% of its local SHBP employers; however, these employers provide coverage to only 56% of the SHBP local active employee population. The remainder have other (private) Rx card plans provided by the public employer.

LOCAL GOVERNMENT SHBP EMPLOYERS				
	Government Employers	Employees Covered	As a % of all Gov. Employers	As a % of all Gov. Employees
Employers with SHBP Employee RX Plan	250	17,322	39%	37%
Employers Providing Rx thru SHBP Medical Plans*	294	11,750	46%	25%
Employers with Private Rx Plan	90	17,396	14%	37%
Total	634	46,468	100%	100%

LOCAL EDUCATION SHBP EMPLOYERS				
	Education Employers	Employees Covered	As a % of all Ed. Employers	As a % of all Ed. Employees
Employers with SHBP Employee RX Plan	94	17,541	32%	23%
Employers Providing Rx thru SHBP Medical Plans*	136	20,504	47%	28%
Employers with Private Rx Plan	62	36,155	21%	49%
Total	292	74,200	100%	100%

*Rx coverage is provided through each SHBP medical plan if the employer does not provide separate Rx plan; the employer is charged a higher medical plan rate as a result of this additional coverage.

Note: Local Education Employers represent only 31% of the SHBP participating local employer population; however, their employees represent 61% of all SHBP local active employees.

Certain columns may not equal 100% due to rounding.

All data as of June 2006.

STATE OF NEW JERSEY
HEALTH BENEFITS PROGRAM FUNDS,
DENTAL EXPENSE PROGRAM FUNDS, AND
PRESCRIPTION DRUG PROGRAM FUNDS

June 30, 2006

INDEX

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Independent Auditors' Report

Office of Legislative Services
Office of the State Auditor
State of New Jersey:

We have audited the accompanying financial statements of the State of New Jersey Health Benefits Program Funds, Dental Expense Program Funds, and Prescription Drug Program Funds (the Funds) as of and for the year ended June 30, 2006, which collectively comprise the Funds' basic financial statements as listed in the accompanying index. These financial statements are the responsibility of the Funds' management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Fund's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

As discussed in Note 1, the financial statements present only the Funds and are not intended to present fairly the financial position and results of operations of the State of New Jersey Division of Pensions and Benefits or the State of New Jersey.

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the State of New Jersey Health Benefits Program Funds, Dental Expense Program Funds, and Prescription Drug Program Funds as of June 30, 2006, and the respective changes in financial position and cash flows for the year then ended in conformity with U.S. generally accepted accounting principles.

Management's Discussion and Analysis is not a required part of the basic financial statements but is supplementary information required by U.S. generally accepted accounting principles. We have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the required supplementary information. However, we did not audit the information and express no opinion on it.

The information included in the schedule of loss development information is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information has not been subjected to the audit procedures applied in the audits of the basic financial statements, and accordingly, we express no opinion on it.

KPMG LLP

January 25, 2007

STATE OF NEW JERSEY
HEALTH BENEFITS PROGRAM FUNDS, DENTAL EXPENSE PROGRAM FUNDS, AND PRESCRIPTION DRUG PROGRAM FUNDS

Management's Discussion and Analysis

June 30, 2006

Our discussion and analysis of the financial performance of the Health Benefits Program Funds – State and Local, Dental Expense Program Funds – State and Local, and Prescription Drug Program Funds – State and Local (the Funds) provides an overview of the Funds' financial activities for the fiscal year ended June 30, 2006. Please read it in conjunction with the basic financial statements and financial statement footnotes which follow this discussion.

FINANCIAL HIGHLIGHTS

Governmental Activities:

- For Health Benefits Program-State, net assets decreased by $0.8 million, increasing the deficit from $(27.4) million to $(28.2) million. For Prescription Drug Program-State, net assets increased by $35.5 million from $34.9 million to $70.4 million. For Dental Expense Program-State, net assets increased by $2.4 million from $2.7 million to $5.1 million.
- Revenues recognized during the year were as follows: $1.1 billion for the Health Benefits Program-State; $272.5 million for the Prescription Drug Program-State; and $78.8 million for the Dental Expense Program-State.
- Expenses incurred during the year were as follows: $1.1 billion for the Health Benefits Program-State; $237.0 million for the Prescription Drug Program-State; and $76.3 million for the Dental Expense Program-State.

Business-Type Activities:

- For Health Benefits Program-Local, net assets increased by $147.7 million from $196.6 million to $344.3 million. For Prescription Drug Program-Local, net assets increased by $7.8 million from $21.3 million to $29.1 million. For Dental Expense Program-Local which became effective January 1, 2005, net assets decreased by $1.6 million from $(1.2) million to $(2.8) million.
- Revenues recognized during the year were as follows: $2.0 billion for the Health Benefits Program-Local; $99.6 million for the Prescription Drug Program-Local; and $16.4 million for the Dental Expense Program-Local.
- Expenses incurred during the year were as follows: $1.8 billion for the Health Benefits Program-Local; $91.9 million for the Prescription Drug Program-Local; and $18.0 million for the Dental Expense Program-Local.

OVERVIEW OF THE FINANCIAL STATEMENTS

Government-wide financial statements

Government-wide financial statements include the following governmental activities and business-type activities:

Governmental Activities:

Health Benefits Program – State

Prescription Drug Program – State

Dental Expense Program – State

Business-Type Activities:

Health Benefits Program – Local

Prescription Drug Program – Local

Dental Expense Program – Local

The government-wide financial statements consist of the statement of net assets and the statement of activities. The statement of net assets presents information on all of the assets and liabilities of the Funds, with the difference between the two reported as net assets (deficit). Over time, increases or decreases in the net assets (deficit) provide one indication of whether the financial health of the Funds is improving or declining. The statement of activities presents information showing how the Funds' net assets (deficit) changed during the most recent fiscal year. All changes in net assets (deficit) are reported as soon as the underlying event giving rise to the change occurs, regardless of the timing of related cash flows.

Fund financial statements

A fund is a grouping of related accounts that is used to maintain control over resources that have been segregated for specific activities or objectives. The State of New Jersey Division of Pensions and Benefits (the Division) uses fund accounting to ensure and demonstrate compliance with finance-related legal requirements.

The Health Benefits Program Fund-State, Dental Expense Program Fund-State, and Prescription Drug Program Fund-State are classified as Governmental Funds. The Health Benefits Program Fund-Local, the Dental Expense Program Fund-Local, and the Prescription Drug Program Fund-Local are classified as Proprietary Funds.

Governmental Funds:

Unlike the government-wide financial statements, governmental fund financial statements focus on near-term inflows and outflows of spendable resources, as well as on balances of spendable resources available at the end of the fiscal year.

Because the focus of governmental funds is narrower than that of the government-wide financial statements, it is useful to compare the information presented for governmental funds with similar information presented in the government-wide financial statements. By doing so, readers may better understand the long-term impact of the Funds' long-term financing decisions. Both the governmental fund balance sheet and the governmental fund statement of revenues, expenditures, and changes in fund balances provide a reconciliation to facilitate this comparison between governmental funds and governmental activities.

Proprietary Funds:

Proprietary funds include funds that are classified as Enterprise funds. Enterprise funds account for operations that are financed and operated in a manner similar to business enterprises with the intent that the costs of providing services on a continuing basis be financed or recovered primarily through user charges.

Like government-wide financial statements, the financial statements of the proprietary funds were prepared using the accrual basis of accounting. The basic proprietary fund financial statements consist of the statement of net assets, the statement of revenues, expenses, and changes in net assets (deficit), and the statement of cash flows. The statement of cash flows provides detail about the individual sources and uses of cash associated with operating activities and noncapital financing activities.

The financial statements report information about the Funds and about their activities to help you assess whether the Funds have improved or declined as a result of the year's activities. For the proprietary funds, the financial statements were prepared using the accrual basis of accounting. Under the accrual basis of accounting, revenues are recognized in the period they are earned, and expenses are recorded in the year they are incurred, regardless of when cash is received or paid. The modified accrual basis of accounting was used for measuring financial position and changes in financial position for the governmental funds. Under this method, revenues are recognized when measurable and available, and expenditures are recognized when incurred and measurable.

The governmental fund *Balance Sheet* and the proprietary fund *Statement of Net Assets* show the balances in all of the assets and liabilities of the Funds at the end of the fiscal year. The difference between assets and liabilities represents the Funds' fund balances or net assets. Over time, increases or decreases in the fund balances or net assets provide one indication of whether the financial health of the Funds is improving or declining. The governmental fund *Statement of Revenues, Expenditures, and Changes in Fund Balances* and the proprietary fund *Statement of Revenues, Expenses, and Changes in Net Assets (Deficit) s*how the results of financial operations for the year. These statements provide an explanation for the change in the Funds' fund balances or net assets since the prior year. The *Statement of Cash Flows* provides detail about the individual sources and uses of cash associated with operating activities and noncapital financing activities of the proprietary funds. These financial statements should be reviewed along with the information contained in the financial statement footnotes to determine whether the Funds are becoming financially stronger or weaker.

FINANCIAL ANALYSIS

SCHEDULE OF NET ASSETS (DEFICIT)

***Governmental Activities*:**

	2006	2005	Increase (Decrease)
Assets	$251,865,493	$203,595,080	$48,270,413
Liabilities	204,495,652	193,408,330	10,087,322
Net Assets (Deficit)	$47,369,841	$10,186,750	$37,183,091

***Business-Type Activities*:**

	2006	2005	Increase (Decrease)
Assets	$670,285,241	$518,065,490	$152,219,751
Liabilities	299,755,439	301,420,577	(1,665,138)
Net Assets (Deficit)	$370,529,802	$216,644,913	$153,884,889

Assets mainly consist of cash, investments, and contributions due from members, participating employers and former members who are covered under the rules of the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and contributions due from Public Employees' Retirement System (PERS) and Teachers' Pension and Annuity Fund (TPAF) to provide funding for post-retirement medical benefits. For the Governmental Activities, between fiscal years 2005 and 2006, total assets increased by $48.3 million or 23.7%. For the Business-Type Activities, total assets increased by $152.2 million or 29.4%. The increase in total assets is mainly due to an increase in fair value balances invested in the Cash Management Fund (CMF) and contributions.

Liabilities mainly consist of outstanding medical and long-term disability claim payments, including incurred but not reported (IBNR) claims. For the Governmental Activities, total liabilities increased by $11.1 million or 5.7%. For the Business-Type Activities, total liabilities decreased by $1.7 million or 0.6%. The increase in total liabilities is mainly due to an increase in short-term claims payable.

For the Governmental Activities, net assets increased by $37.2 million or 365.0%. For the Business-Type Activities, net assets increased by $153.9 million or 71.0%. The increase in net assets is due to an increase in fair value of investments and revenues exceeding expenses.

REVENUES - ADDITIONS TO NET ASSETS (DEFICIT)

Governmental Activities:

	2006	2005	Increase (Decrease)
Member Contributions	$121,243,229	$114,227,002	$7,016,227
Employer Contributions	1,341,902,826	1,271,991,065	69,911,761
CMF Investment & Other	9,447,487	3,558,790	5,888,697
Totals	$1,472,593,542	$1,389,776,857	$82,816,685

Business-Type Activities:

	2006	2005	Increase (Decrease)
Member Contributions	$102,417,616	$93,328,849	$9,088,767
Employer Contributions	1,989,284,460	1,837,856,549	151,427,911
CMF Investment & Other	21,155,791	8,674,083	12,481,708
Totals	$2,112,857,867	$1,939,859,481	$172,998,386

Revenues primarily consist of member and employer contributions and earnings from CMF Investment activities. For the Governmental Activities, revenues increased by $82.8 million or 6.0%. For the Business-Type Activities, total revenues increased by $173.0 million or 8.9%. The increase in revenues is attributable to an increase in the premium rates for the health, dental, and prescription drug plans. Member contributions increased by 6.1% for the Governmental Activities and by 9.7% for the Business-Type Activities for the same reason. The increase in investment and other revenues is primarily due to a higher CMF rate of return.

EXPENSES - DEDUCTIONS FROM NET ASSETS (DEFICIT)

Governmental Activities:

	2006	2005	Increase (Decrease)
Benefits	$1,431,885,833	$1,353,189,620	$78,696,213
Administrative Expenses	3,524,618	2,564,676	959,942
Totals	$1,435,410,451	$1,355,754,296	$79,656,155

Expenses primarily consist of claim charges for the self-insured health, prescription drug, and dental plans, premium charges for the insured health and dental programs, and administrative expenses. During the year, expenses increased by $79.7 million or 5.9% for the Governmental Activities. For the insured plans, expenses increased due to the higher premium rates for calendar year 2006. The average premium rate increase for all plans is 10.7% for active members and 6.4% for retirees in calendar year 2006. For the self-insured plans, the increase in benefit expenses was due to higher claim charges, which is attributable to the rising cost of health services.

Business-Type Activities:

	2006	2005	Increase (Decrease)
Benefits	$1,953,686,050	$1,856,716,744	$96,969,306
Administrative Expenses	5,286,928	3,847,014	1,439,914
Totals	$1,958,972,978	$1,860,563,758	$98,409,220

Expenses primarily consist of claim charges for the self-insured health, prescription drug, and dental plans, premium charges for the insured health and dental programs, and administrative expenses. During the year, expenses increased by $98.4 million or 5.3% for the Business-Type Activities. For the insured plans, expenses increased due to higher premium rates for calendar year 2006. The average premium rate increase for all plans is 12.3% for active members and 2.2% for retirees in calendar year 2006. For the self-insured plans, the increase in benefit expenses was due to higher claim charges, which is attributable to the rising cost of health services.

OVERALL FINANCIAL CONDITION OF THE FUNDS

The Health Benefits Program Fund – For State, the Fund is using a portion of the reserve balance to cover the premiums for covered members. For Local, contributions received by the Fund to pay the premiums for covered members are keeping pace with the rising health costs and produce a necessary reserve balance. Management intends that through further rate actions and other initiatives, the Funds will maintain sufficient reserves.

The Prescription Drug - State and Local received contributions to meet this year's benefit obligations and to maintain a sufficient reserve. Through further rate actions and other initiatives, management intends that the financial condition of these benefit programs will remain stable.

The Dental Expense Program – State received contributions to meet this year's benefit obligations and to maintain a sufficient reserve.

CONTACTING SYSTEM FINANCIAL MANAGEMENT

The financial report is designed to provide our members, beneficiaries, investors and creditors with a general overview of the Funds' finances and to show the Funds' accountability for the money it receives. If you have any questions about this report or need additional financial information, contact the Division of Pensions and Benefits, P.O. Box 295, Trenton, NJ 08625-0295.

STATE OF NEW JERSEY
HEALTH BENEFITS PROGRAM FUNDS,
DENTAL EXPENSE PROGRAM FUNDS, AND
PRESCRIPTION DRUG PROGRAM FUNDS

Statement of Net Assets

June 30, 2006

	GOVERNMENTAL ACTIVITIES	BUSINESS-TYPE ACTIVITIES	TOTAL
Assets:			
Cash and cash equivalents	$ 164,872	5,541,038	$ 5,705,910
Investments, at fair value:			
Cash Management Fund	243,973,416	570,485,699	814,459,115
Total investments	243,973,416	570,485,699	814,459,115
Receivables:			
Other	7,475,857	91,599,515	99,075,372
Due from other funds	251,348	2,658,989	2,910,337
Total receivables	7,727,205	94,258,504	101,985,709
Total assets	$ 251,865,493	670,285,241	$ 922,150,734
Liabilities:			
Accounts payable and accrued expenses	$ 54,249,638	44,080,631	$ 98,330,269
Cash overdraft	232,680	46,803	279,483
Incurred but not reported claims	148,600,000	252,600,000	401,200,000
Deferred revenue	915,975	—	915,975
Other	246,011	369,016	615,027
Due to other funds	251,348	2,658,989	2,910,337
Total liabilities	204,495,652	299,755,439	504,251,091
Net assets - unrestricted	$ 47,369,841	370,529,802	$ 417,899,643
Total liabilities and net assets - unrestricted	$ 251,865,493	670,285,241	$ 922,150,734

See accompanying notes to financial statements.

STATE OF NEW JERSEY
HEALTH BENEFITS PROGRAM FUNDS,
DENTAL EXPENSE PROGRAM FUNDS, AND
PRESCRIPTION DRUG PROGRAM FUNDS

Statement of Activities

Year Ended June 30, 2006

Functions/Programs	Expenses	Program Revenues Charges for Services (Contributions)	Net (Expense) Revenue and Changes in Net Assets (Deficit) Governmental Activities	Business-Type Activities	TOTAL
Primary government:					
Governmental activities:					
Health Benefits Program - State	$ 1,122,095,339	1,114,603,302	(7,492,037)	—	$ (7,492,037)
Dental Expense Program -State	76,329,011	78,235,312	1,906,301	—	1,906,301
Prescription Drug Program - State	236,986,101	270,307,441	33,321,340	—	33,321,340
Total governmental activities	1,435,410,451	1,463,146,055	27,735,604	—	27,735,604
Business-type activities:					
Health Benefits Program - Local	1,849,062,473	1,976,169,341	—	127,106,868	127,106,868
Dental Expense Program -Local	18,024,622	16,423,155	—	(1,601,467)	(1,601,467)
Prescription Drug Program - Local	91,885,883	99,109,580	—	7,223,697	7,223,697
Total business-type activities	1,958,972,978	2,091,702,076	—	132,729,098	132,729,098
Total primary government	$ 3,394,383,429	3,554,848,131	27,735,604	132,729,098	$ 160,464,702
General Revenues :					
Investment Earnings			$ 9,447,487	21,155,791	$ 30,603,278
Total general revenues			9,447,487	21,155,791	30,603,278
Change in Net Assets			37,183,091	153,884,889	191,067,980
Net assets - Beginning of year			10,186,750	216,644,913	226,831,663
Net assets - End of year			$ 47,369,841	370,529,802	$ 417,899,643

See accompanying notes to financial statements.

STATE OF NEW JERSEY
HEALTH BENEFITS PROGRAM FUNDS,
DENTAL EXPENSE PROGRAM FUNDS, AND
PRESCRIPTION DRUG PROGRAM FUNDS

Balance Sheet
Governmental Funds

June 30, 2006

	HEALTH BENEFITS PROGRAM FUND STATE	DENTAL EXPENSE PROGRAM FUND STATE	PRESCRIPTION DRUG PROGRAM FUND STATE	TOTAL
Assets:				
Cash and cash equivalents	$ —	—	164,872	$ 164,872
Investments, at fair value:				
Cash Management Fund	154,589,166	14,342,525	75,041,725	243,973,416
Total investments	154,589,166	14,342,525	75,041,725	243,973,416
Receivables:				
Other	6,204,460	1,239,128	32,269	7,475,857
Due from other funds	148,799	102,549	—	251,348
Total receivables	6,353,259	1,341,677	32,269	7,727,205
Total assets	$ 160,942,425	15,684,202	75,238,866	$ 251,865,493
Liabilities:				
Accounts payable and accrued expenses	$ 48,106,143	1,443,495	4,700,000	$ 54,249,638
Cash overdraft	45,652	187,028	—	232,680
Deferred revenue	—	915,975	—	915,975
Other	246,011	—	—	246,011
Due to other funds	102,549	—	148,799	251,348
Total liabilities	48,500,355	2,546,498	4,848,799	55,895,652
Fund Balances:				
Unreserved	112,442,070	13,137,704	70,390,067	195,969,841
Total liabilities and fund balances	$ 160,942,425	15,684,202	75,238,866	$ 251,865,493
Fund balances	$ 112,442,070	13,137,704	70,390,067	$ 195,969,841
Amounts reported in the statement of net assets are different because:				
The IBNR long-term liabilities are not due and payable in the current period and therefore not reported in the funds.	(140,600,000)	(8,000,000)	—	(148,600,000)
Net Assets (Deficits)	$ (28,157,930)	5,137,704	70,390,067	$ 47,369,841

See accompanying notes to financial statements.

STATE OF NEW JERSEY
HEALTH BENEFIT PROGRAM FUNDS,
DENTAL EXPENSE PROGRAM FUNDS, AND
PRESCRIPTION DRUG PROGRAM FUNDS

Statement of Revenues, Expenditures, and Changes in Fund Balances
Governmental Funds

Year Ended June 30, 2006

	HEALTH BENEFITS PROGRAM FUND STATE	DENTAL EXPENSE PROGRAM FUND STATE	PRESCRIPTION DRUG PROGRAM FUND STATE	TOTAL
Revenues:				
Contributions:				
Members	$ 77,276,972	42,396,990	1,569,267	$ 121,243,229
Employers	1,037,326,330	35,838,322	268,738,174	1,341,902,826
Total contributions	1,114,603,302	78,235,312	270,307,441	1,463,146,055
Investment income:				
Net appreciation in fair value of investments	7,743	774	3,492	12,009
Interest	6,712,722	557,352	2,165,404	9,435,478
Total investment income	6,720,465	558,126	2,168,896	9,447,487
Total revenues	1,121,323,767	78,793,438	272,476,337	1,472,593,542
Expenditures:				
Benefits	1,114,764,721	74,574,011	236,986,101	1,426,324,833
Administrative expenditures	3,524,618	—	—	3,524,618
Total expenditures	1,118,289,339	74,574,011	236,986,101	1,429,849,451
Excess of revenues over expenditures	3,034,428	4,219,427	35,490,236	42,744,091
Fund Balances:				
Beginning of year	109,407,642	8,918,277	34,899,831	153,225,750
End of year	$ 112,442,070	13,137,704	70,390,067	$ 195,969,841
Benefits - Modified Accrual	1,114,764,721	74,574,011	236,986,101	1,426,324,833
Benefits - Full Accrual	1,118,570,721	76,329,011	236,986,101	1,431,885,833
Adjustment of IBNR	(3,806,000)	(1,755,000)	—	(5,561,000)
Change in Net Assets	$ (771,572)	2,464,427	35,490,236	$ 37,183,091

See accompanying notes to financial statements.

STATE OF NEW JERSEY
HEALTH BENEFIT PROGRAM FUNDS,
DENTAL EXPENSE PROGRAM FUNDS, AND
PRESCRIPTION DRUG PROGRAM FUNDS

Statement of Net Assets
Proprietary Funds

June 30, 2006

	HEALTH BENEFITS PROGRAM FUND LOCAL	DENTAL EXPENSE PROGRAM FUND LOCAL	PRESCRIPTION DRUG PROGRAM FUND LOCAL	TOTAL
Assets:				
Cash and cash equivalents	$ 5,288,613	—	252,425	$ 5,541,038
Investments, at fair value:				
Cash Management Fund	550,590,949	58,705	19,836,045	570,485,699
Total investments	550,590,949	58,705	19,836,045	570,485,699
Receivables:				
Other	83,421,607	15,717	8,162,191	91,599,515
Due from other funds	55,368	—	2,603,621	2,658,989
Total receivables	83,476,975	15,717	10,765,812	94,258,504
Total assets	$ 639,356,537	74,422	30,854,282	$ 670,285,241
Liabilities:				
Accounts payable and accrued expenses	$ 44,080,631	—	—	$ 44,080,631
Incurred but not reported claims	248,000,000	2,800,000	1,800,000	252,600,000
Cash overdraft	—	46,803	—	46,803
Other	369,016	—	—	369,016
Due to other funds	2,603,621	55,368	—	2,658,989
Total liabilities	295,053,268	2,902,171	1,800,000	299,755,439
Net Assets	$ 344,303,269	(2,827,749)	29,054,282	$ 370,529,802

See accompanying notes to financial statements.

STATE OF NEW JERSEY
HEALTH BENEFIT PROGRAM FUNDS,
DENTAL EXPENSE PROGRAM FUNDS, AND
PRESCRIPTION DRUG PROGRAM FUNDS

Statement of Revenues, Expenses, and Changes in Net Assets
Proprietary Funds

Year Ended June 30, 2006

	HEALTH BENEFITS PROGRAM FUND LOCAL	DENTAL EXPENSE PROGRAM FUND LOCAL	PRESCRIPTION DRUG PROGRAM FUND LOCAL	TOTAL
Operating Revenues:				
Contributions:				
Members	$ 86,096,006	15,656,486	665,124	$ 102,417,616
Employers	1,890,073,335	766,669	98,444,456	1,989,284,460
Total operating revenues	1,976,169,341	16,423,155	99,109,580	2,091,702,076
Operating Expenses:				
Benefits	1,843,775,545	18,024,622	91,885,883	1,953,686,050
Administrative expense	5,286,928	—	—	5,286,928
Total operating expenses	1,849,062,473	18,024,622	91,885,883	1,958,972,978
Operating income (loss)	127,106,868	(1,601,467)	7,223,697	132,729,098
Non-operating revenue:				
Investment income:				
Net appreciation in fair value of investments	32,504	50	873	33,427
Interest	20,557,520	23,493	541,351	21,122,364
Total non-operating revenue	20,590,024	23,543	542,224	21,155,791
Change in net assets	147,696,892	(1,577,924)	7,765,921	153,884,889
Net Assets:				
Beginning of year	196,606,377	(1,249,825)	21,288,361	216,644,913
End of year	$ 344,303,269	(2,827,749)	29,054,282	$ 370,529,802

See accompanying notes to financial statements.

STATE OF NEW JERSEY
HEALTH BENEFITS PROGRAM FUNDS,
DENTAL EXPENSE PROGRAM FUNDS, AND
PRESCRIPTION DRUG PROGRAM FUNDS

Statement of Cash Flows
Proprietary Funds

Year Ended June 30, 2006

	HEALTH BENEFITS PROGRAM FUND LOCAL	DENTAL EXPENSE PROGRAM FUND LOCAL	PRESCRIPTION DRUG PROGRAM FUND LOCAL	TOTAL
Cash flows from operating activities:				
Receipts - Employer contributions	$ 1,884,075,002	751,792	95,475,346	$ 1,980,302,140
Receipts - Member contributions	86,448,091	15,674,162	656,625	102,778,878
Benefit payments	(1,809,434,622)	(17,082,318)	(91,885,883)	(1,918,402,823)
Premium payments	(36,706,527)	—	—	(36,706,527)
Administrative expense	(5,358,620)	—	—	(5,358,620)
Net cash provided by (used in) operating activities	119,023,324	(656,364)	4,246,088	122,613,048
Cash flows from non-capital financing activities:				
Cash overdraft	—	46,803	—	46,803
Net cash provided by non-capital financing activities	—	46,803	—	46,803
Cash flows from investing activities:				
Interest and dividends	20,557,520	23,493	541,351	21,122,364
Sale (purchase) of investments	(134,075,282)	551,783	(4,965,231)	(138,488,730)
Net cash provided by (used in) investing activities	(113,517,762)	575,276	(4,423,880)	(117,366,366)
Increase (decrease) in cash equivalents	5,505,562	(34,285)	(177,792)	5,293,485
Cash and cash equivalents beginning of year	(216,949)	34,285	430,217	247,553
Cash and cash equivalents end of year	$ 5,288,613	—	252,425	$ 5,541,038
Reconciliation of operating income to net cash provided by (used in) operating activities:				
Operating income (loss)	$ 127,106,868	(1,601,467)	7,223,697	$ 132,729,098
Adjustments to reconcile operating income (loss) to net cash used by (used in) operating activities:				
Changes in assets and liabilities:				
(Increase) decrease in receivables	(5,603,944)	2,799	(2,977,609)	(8,578,754)
Increase in due from other funds	(42,304)	—	—	(42,304)
(Decrease) increase in accounts payable and accrued expenses	(4,561,631)	900,000	—	(3,661,631)
Increase in due to other funds	2,124,335	42,304	—	2,166,639
Net cash provided by (used in) operating activities	$ 119,023,324	(656,364)	4,246,088	$ 122,613,048
Non-cash transactions:				
Change in fair value of investments	$ 32,504	50	873	33,427

See accompanying notes to financial statements.

STATE OF NEW JERSEY
HEALTH BENEFITS PROGRAM FUNDS,
DENTAL EXPENSE PROGRAM FUNDS, AND
PRESCRIPTION DRUG PROGRAM FUNDS

Notes to Financial Statements

June 30, 2006

(1) DESCRIPTION OF THE FUNDS

The State of New Jersey sponsors and administers the following funds which have been included in the accompanying financial statements of the State of New Jersey Division of Pensions and Benefits (the Division):

Governmental funds:

State Health Benefits Program Fund (SHBP) - State
Dental Expense Program Fund (DEPF) - State
Prescription Drug Program Fund (PDPF) - State

Proprietary funds:

State Health Benefits Program Fund (SHBP) – Local
Dental Expense Program Fund (DEPF) - Local
Prescription Drug Program Fund (PDPF) - Local

The financial statements of these funds and accounts have been prepared in conformity with accounting principles generally accepted in the United States of America as applied to governmental units. The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for establishing governmental accounting and financial reporting principles. The more significant of the Division's accounting policies are described below.

Reporting entity:

The financial statements include the State and Local Health Benefit Funds, State and Local Dental Program Funds, and State and Local Prescription Drug Program Funds, which are administered by the Division over which operating controls are with the individual funds governing Boards and/or the State of New Jersey. The financial statements of the funds are included in the financial statements of the State of New Jersey; however, the accompanying financial statements are intended to present solely the funds listed above which are administered by the Division and not the State of New Jersey as a whole.

Fund accounting:

The accounts of the Division are maintained in accordance with the principles of fund accounting to ensure observance of limitations and restrictions on the resources available. The principles of fund accounting require that the resources be classified for accounting and reporting purposes into funds in accordance with activities or objectives specified for the resources. Each fund is a separate accounting entity with a self-balancing set of accounts. Funds are classified into two categories: governmental and proprietary.

Governmental funds:

Governmental funds account for proceeds of specific revenue sources that are legally restricted for expenditure for specified purposes.

Proprietary funds:

Proprietary funds account for operations that are financed and operated in a manner similar to business enterprises with the intent that the costs of providing services on a continuing basis be financed or recovered primarily through user charges.

(2) SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Measurement Focus and Basis of Accounting:

The accounting and financial reporting treatment applied to a fund is determined by its measurement focus. All funds, except for the governmental funds, are accounted for using an economic resources measurement focus.

The governmental funds are accounted for using a current financial resources measurement focus and modified accrual basis of accounting. With this measurement focus, only current assets and current liabilities generally are included on the balance sheet. Operating statements of these funds present increases, i.e., revenues and other financing additions, and decreases, i.e., expenditures and other deductions, in net assets.

The modified accrual basis of accounting is used for measuring financial position and changes in financial position for the governmental funds. Under this method, revenues are recognized when measurable and available, and expenditures are recognized when due and payable.

The focus of the government-wide statements and proprietary funds measurement is upon determination of net income, financial position and cash flows. The generally accepted accounting principles applicable are those similar to businesses in the private sector.

Capital Assets:

Capital assets utilized by the Division include equipment which is owned by the State of New Jersey.

Investment Valuation:

Investments, including short-term investments (State of New Jersey Cash Management Funds) are reported at fair value.

The State of New Jersey Division of Investment, under the jurisdiction of the State Investment Council, has the investment responsibility for all funds administered by the State of New Jersey Division of Pensions and Benefits. All investments must conform to standards set by state law.

The State of New Jersey, Department of the Treasury, Division of Investment, issues publicly available financial reports that include the financial statements of the State of New Jersey Cash Management Fund. The financial reports may be obtained by writing to the State of New Jersey, Department of the Treasury, Division of Investment, P.O. Box 290, Trenton, New Jersey 08625-0290.

The purchase, sale, receipt of income, and other transactions affecting investments are governed by custodial agreements between the Funds, through the State Treasurer, and custodian banks as agents for the Funds. State laws and policies set forth the requirements of such agreements and other particulars as to the size of the custodial institutions, amount of the portfolio to be covered by the agreements, and other pertinent matters.

Investments:

The Funds' investments as of June 30, 2006 consist of an interest in the Cash Management Funds. The Cash Management Fund is not evidenced by securities that exist in physical or book entry form held by the Funds, and it is unrated.

New Legislation:

Chapter 375, P.L. 2005 required health insurers and SHBP providing dependent coverage to provide for election of coverage by certain dependents until their 30th birthday, effective January 1, 2007.

Membership:

Membership in the funds administered by the Division consisted of the following as of June 30, 2006:

	STATE	LOCAL	TOTAL
Health Benefits Program Fund*	149,272	215,175	364,447
Prescription Drug Program Fund*	115,280	35,786	151,066
Dental Expense Program Fund*	113,872	27,844	141,716

* active and retired participants

Administrative Expenses:

Administrative expenses are paid by the funds to the State of New Jersey, Department of the Treasury and are included in the accompanying statements of changes in net assets and fund balances.

(3) CONTRIBUTIONS

Contribution Requirements - SHBP- State and Local

Contributions to pay for the health premiums of participating employees in the State Health Benefits Program (SHBP) are collected from the State of New Jersey, participating local employers, active members, retired members, the Public Employees' Retirement System (PERS), and the Teachers' Pension and Annuity Fund (TPAF). The State of New Jersey provides contributions for State employees through State appropriations. These appropriations are generally distributed to the SHBP on a monthly basis. Local employer payments, active and retired member contributions, and payments from the PERS and TPAF are generally received on a monthly basis. Certain State employees share in the cost of their premiums, as provided by Chapter 8, P.L. 1996.

Under the provisions of Chapter 8, P.L. 1996, the SHBP implemented premium sharing for employees covered under the State component of the program. Chapter 8 authorizes the State to negotiate premium sharing in the collective bargaining agreements governing employment of State employees. Premium sharing also applies to Retired group coverage for employees who attain 25 years of creditable pension service after July 1, 1997 or who retire on a Disability retirement after that same date. Those employees not represented by any bargaining unit premium share in accordance with rules established by the State Health Benefits Commission. Local group employees are not affected by the premium sharing provisions of Chapter 8, P.L. 1996.

Contribution Requirements - PDPF- State and Local

Contributions to pay for the premiums of participating employees in the Prescription Drug Program Fund are collected from the State of New Jersey, participating local employers, and former active and retired members who have elected to participate under the rules of COBRA. The State of New Jersey provides contributions for State employees through State appropriations. These appropriations are distributed to the PDPF on a monthly basis. Local employer payments as well as COBRA contributions are also received on a monthly basis.

Contribution Requirements – DEPF- State and Local

Contributions to pay for the premiums of participating employees in the Employee Dental Expense Program Fund are collected from the State of New Jersey, local governmental and educational employers, active employees, and former and retired members who have elected to participate under the rules of COBRA. The cost of the premiums is shared by the State of New Jersey and active State employees. Former and retired employees who have chosen to participate under the rules of COBRA pay the full cost of the premium. The employers are billed for the full cost of coverage. The State of New Jersey provides contributions through State appropriations. These appropriations are distributed to the DEPF on a biweekly and monthly basis. The active member share of the cost of premiums, which is included in the billing to the employers, is paid to the State on a biweekly and monthly basis. Members participating under COBRA remit their payments on a monthly basis.

(4) VESTING AND BENEFITS

Vesting and Benefit Provisions - SHBP - State and Local

The Program provides medical coverage to qualified active and retired participants. Under Chapter 136, P.L. 1977, the State of New Jersey pays for the health insurance coverage of all enrolled retired State employees (regardless of age) whose pensions are based upon 25 years or more of credited service or a disability retirement regardless of years of service. The State of New Jersey also provides free coverage to members of the Public Employees' Retirement System, Teachers' Pension and Annuity Fund, and the Alternate Benefit Program who retire from a board of education or county college with 25 years of service or on a disability retirement. Partially funded benefits are also provided to local police officers and firefighters who retire with 25 years of service (or on disability) from an employer who does not provide coverage. Retirees who are not eligible for employer paid health coverage at retirement can continue in the program by paying the cost of the insurance for themselves and their covered dependents.

Benefit Provisions - PDPF - State and Local

The Program provides coverage to employees and their eligible dependents for drugs which under federal or State law may be dispensed only upon a prescription written by a physician. State and local employees are eligible for coverage after 60 days of employment.

Benefit Provisions - DEPF- State and Local

The Program provides coverage to employees and their eligible dependents for dental services performed by a qualified dentist. Employees are eligible for coverage after 60 days of employment.

(5) UNPAID CLAIMS LIABILITIES

As discussed in Note 2, the proprietary funds established liabilities for both reported and unreported claims, which includes estimates of future payments of claims and related claim adjustment expenses. The following represent changes in those aggregate liabilities for Governmental Activities and Business-Type Activities during the year:

	HEALTH BENEFITS PROGRAM FUND STATE	PRESCRIPTION DRUG PROGRAM FUND STATE	DENTAL EXPENSE PROGRAM FUND STATE
Unpaid claims at beginning of year	$ 175,616,877	$ 4,900,000	$ 7,322,427
Incurred claims:			
Provision for insured events of current year	1,114,764,721	236,986,101	74,574,011
Payments	(1,104,120,240)	(237,186,101)	(72,706,974)
Unpaid claims at end of year	$ 186,261,358	$ 4,700,000	$ 9,189,464

STATE OF NEW JERSEY
HEALTH BENEFITS PROGRAM FUNDS,
DENTAL EXPENSE PROGRAM FUNDS, AND
PRESCRIPTION DRUG PROGRAM FUNDS

Notes to Financial Statements

June 30, 2006

	HEALTH BENEFITS PROGRAM FUND LOCAL	PRESCRIPTION DRUG PROGRAM FUND LOCAL	DENTAL EXPENSE PROGRAM FUND LOCAL
Unpaid claims at beginning of year	$ 296,557,278	$ 1,800,000	$ 1,900,000
Incurred claims:			
Provision for insured events of current year	1,843,775,545	91,885,883	18,024,622
Payments	(1,848,271,465)	(91,885,883)	(17,124,622)
Unpaid claims at end of year	$ 292,061,358	$ 1,800,000	$ 2,800,000

Schedule 1

STATE OF NEW JERSEY
HEALTH BENEFITS PROGRAM FUNDS,
DENTAL EXPENSE PROGRAM FUNDS, AND
PRESCRIPTION DRUG PROGRAM FUNDS

Supplementary Information

Schedule of Loss Development Information

June 30, 2006

HEALTH BENEFITS PROGRAM FUND - LOCAL		**FISCAL YEAR ENDED JUNE 30, 2006**
Premiums and investment revenue earned	$	1,996,759,365
Estimated expenses		1,849,062,473

PRESCRIPTION DRUG PROGRAM FUND - LOCAL		**FISCAL YEAR ENDED JUNE 30, 2006**
Premiums and investment revenue earned	$	99,651,804
Estimated expenses		91,885,883

DENTAL EXPENSE PROGRAM FUND - LOCAL		**FISCAL YEAR ENDED JUNE 30, 2006**
Premiums and investment revenue earned	$	16,446,698
Estimated expenses		18,024,622

APPENDIX A

New Jersey State Health Benefits Program

Related State Legislation

The State Health Benefits Program was established by state statute, cited as N.J.S.A. 52:14-17.25 et. seq. A brief description of the key laws modifying this section of the statute is provided below.

Chapter 49, P.L. 1961 established the State Health Benefits Program. The State Health Benefits Commission was authorized to solicit and award contracts for hospitalization, medical-surgical, and major medical insurance benefits with the cost to be paid by the State for employee coverage. Optional coverage for dependents was to be provided at the employee's expense.

Chapter 125, P.L. 1964 permitted State Health Benefits Program coverage for local public employees at the option of each public employer. This law also allowed continuation of coverage from the Active Group into the Retired Group.

Chapter 75, P.L. 1972 provided for state payment of retired health benefits coverage of all enrolled retired state employees and their dependents, retired after July 1, 1972, whose pensions are based on 25 years of credited service (except those who elected a deferred retirement) or a disability retirement based on fewer years credited service. It also provided for state reimbursement of Part B Medicare premiums for eligible retired State employees and their dependents.

Chapter 111, P.L. 1973 allowed local employers to elect to pay for health benefits coverage and reimburse Part B Medicare premiums of certain eligible retired employees and their dependents. Eligible employees include those who had retired on or after July 1, 1972, and receive a retirement benefit from a state- or locally-administered retirement system based on 25 years of credited service (excluding those who elected a deferred retirement) or retired on a disability pension based on fewer years service.

Chapter 337, P.L. 1973 allowed an employee to elect to enroll in a Health Maintenance Organization. The employee is permitted to elect HMO participation at least once a year.

Chapter 88, P.L. 1974 allowed local employers who had adopted the provisions of Chapter 111, P.L. 1973, to extend coverage to eligible enrolled retirees who retired between July 1, 1964, and June 30,1972.

Chapter 136, P.L. 1977 amended Chapter 75, P.L. 1972 to extend the eligibility for State-paid coverage to those otherwise eligible retirees who retired between July 1, 1964, and June 30, 1972, and were enrolled for Retired Group coverage.

Chapter 54, P.L. 1979 allowed local employers who had adopted the provisions of Chapter 88, P.L. 1974 to extend benefits to those eligible retirees who had retired between July 1, 1964, and the date the employer joined the State Health Benefits Program.

Chapter 436, P.L. 1981 allowed employers who adopted the provisions of Chapter 88, P.L. 1974, to also include surviving spouses of eligible retirees. The law also gave employers who had adopted Chapter 88, P.L. 1974, the option of including otherwise eligible employees who retired after the employer joined the State Health Benefits Program but who had not continued coverage into retirement because they had to pay for it.

Chapter 384, P.L. 1987, although designed to bring benefits for retired teachers in line with those for state retirees, affected many other retirees also. The law permitted the Teachers' Pension and Annuity Fund (TPAF) to pay for the State Health Benefits Program coverage of members receiving retirement allowances based upon 25 or more years of credited service or a disability retirement (regardless of years of service). In addition to paying for the cost of coverage, the pension fund reimburses eligible retirees and/or covered spouses for the cost of Part B (medical insurance) of the federal Medicare program. The TPAF

began paying for coverage as of June 1, 1988. Those eligible retirees not already enrolled were given an opportunity through May 31, 1988, to enroll in the program. One of the most important features of this law is that it applies to all eligible TPAF members (except those who elected a deferred retirement - adjusted by Chapter 126, P.L. 1992), not just those who belong to the State Health Benefits Program while actively employed. Beginning June 1, 1988, a new TPAF retiree qualifying for TPAF-paid coverage was offered the opportunity to join this program.

Another important feature of Chapter 384 was the elimination of the July 1, 1964, restrictions. Previously only those who retired on or after that date could enroll in the State Program. This allowed TPAF members who were eligible for TPAF-paid coverage to join the program regardless of their retirement date. Further, the law amended Chapter 136, P.L. 1977, to permit the State to pay for the coverage of eligible state individuals who retired prior to July 1, 1964; those eligible former state employees who had retired prior to July 1, 1964, even those who had not been teachers, were given an opportunity to enroll as of June 1, 1988. Finally, the law amended Chapter 54, P.L. 1979, to permit local employers who have adopted the provisions of Chapter 88, P.L. 1974, as amended by Chapter 436, P.L. 1981, to also agree to include all former employees who retired before the location joined the State Plan. Originally, Chapter 54 only applied to those who retired on or after July 1, 1964.

Chapter 386, P.L. 1987 required that, as of June 1, 1988, all boards of education in New Jersey must give their retirees an opportunity to join the employer's current health insurance plan. For a one-year period (from June 1, 1988, through May 31, 1989) former employees who were not eligible under another plan (for instance, those eligible under Chapter 384 would not be eligible under Chapter 386) must have been given the opportunity to enroll under the employer's group contract. The retiree would pay the cost of such coverage. If the employer belonged to the State Health Benefits Program, the retiree had the chance to enroll under the State Program regardless of the retirement date.

Chapter 6, P.L. 1989 redefined the qualifications of the carriers or providers of the health benefits with whom the State Health Benefits Commission may contract in order to provide such benefits to participants in the State Health Benefits Program. This law eliminated the former requirements that basically forced the State Health Benefits Program to use two specific carriers.

Chapter 48, P.L. 1989 established the same major medical benefits limit for retired employees in the State Health Benefits Program as is provided to active employees. The lifetime maximum available to retirees was previously significantly less than that provided Active Group employees.

Chapter 127, P.L. 1989 permits school employees who have been employed under a permanent appointment for at least three years to continue State Health Benefits Program coverage when they are on an approved leave of absence with or without pay up to a maximum of two years. The employer may pay the premiums for such coverage in these instances.

Chapter 271, P.L. 1989 provides that the State shall pay the State Health Benefits Program (State Health Benefits Program) costs for the surviving spouse and dependent children of members of the Police and Firemen's Retirement System (PFRS) and the State Police Retirement System (SPRS) who die as a result of an accident met in the actual performance of their duties. Such surviving spouses and dependent children can enroll in the State Health Benefits Program or, if enrolled in a local employer's plan, can obtain reimbursement of required premiums from the State. This law was approved on January 8, 1990, and applies to all present surviving spouses and dependent children of members for whom an accidental death benefit was payable.

Chapter 6, P.L. 1990 provides, in addition to other matters, that the premiums or periodic charges which the State is required to pay for the post-retirement health care benefits under the State Health Benefits Program to retired state employees of PERS and their dependents shall be paid by the retirement system and shall be funded in a manner similar to that provided for the funding of employer obligations for retirement benefits. This law was effective March 8, 1990.

Chapter 126, P.L. 1992 provides that members of the Public Employees' Retirement System (PERS) and the

Alternate Benefits Program (ABP) who retired from a school board of education or a county college with a benefit based upon 25 or more years of service or on a disability pension based upon fewer years of service credit and receive a retirement allowance from that system are eligible for state-paid health coverage regardless of employers' participation in the State Health Benefits Program

Members of PERS, TPAF, and ABP who retire from a school board of education or county college and elect deferred retirement based upon 25 or more years of service credit and receive a retirement allowance from that system will be eligible to enroll in the State Health Benefits Program This law also provides for the State to reimburse Part B Medicare premiums for the retirees' extended benefits under its provisions.

Chapter 8, P.L. 1993 provides that members of PERS, TPAF, and PFRS who retire from a school board of education, vocational/technical school, or a special service commission may be eligible to join the State Health Benefits Program providing they meet the following requirements: the member is currently participating in the health benefit plan of the employer for whom (s)he was previously employed, and (s)he is eligible for the full Medicare Parts A and B.

This law also imposes a surcharge on insurance carriers (including hospital service corporations, medical service corporations, health service corporations, and health maintenance organizations) that provide health coverage to local boards of education that do not participate in the State Health Benefits Program.

Chapter 275, P.L. 1994 makes special provisions for retirement coverage and Medicare reimbursement for a select group of county judicial employees from seven counties who became state employees under the terms of the State Judicial Unification Act. This law was enacted to fulfill the mandate of a 1993 constitutional referendum moving control of county courts to the State. The purpose of the law was to authorize the continuation of certain contractual benefits.

Chapter 259, P.L. 1995 authorizes municipalities which participate in the State Health Benefits Program or another group health benefits plan to allow an employee who is enrolled for health care coverage as a dependent of his/her spouse to waive coverage to which (s)he is entitled as an employee of the municipality. It permits a municipality to pay an employee an amount not to exceed 50% of the amount saved by the municipality because of the waiver. Any municipal employee waiving coverage under the State Health Benefits Program must file such waiver with the Division. Further, an employee who waives coverage shall be able to immediately resume coverage under the State Health Benefits Program if the employee ceases to be covered by the spouse for any reason by filing a declaration with the Division that the waiver is revoked.

Chapter 8, P.L. 1996 applies to state employees in the executive, legislative, and judicial branches of government as well as employees of the state universities and colleges and independent commissions and agencies participating in the State Health Benefits Program. The law applies to local employers only with regards to provisions affecting Medicare reimbursement for active employees and the HMO coverage restrictions. Chapter 8, P.L. 1996 ends Medicare reimbursement for active employees and their spouses; prohibits dual coverage by any individual in two State Health Benefits Program HMO contracts; allows active employee premium sharing resulting from labor contract agreements; allows retiree premium sharing resulting from labor contract agreements; allows adjustments to retiree Medicare reimbursement resulting from labor contract agreements; authorizes the State Health Benefits Commission to establish rules governing active employee and retiree premium sharing and retiree Medicare reimbursement for employees not represented by labor unions, that is, for nonaligned employees; and grandfathers retired health coverage and retiree Medicare reimbursement for employees who retire prior to July 1, 1997, and employees who have 25 years of credited pension service before July 1, 1997, regardless of when they retire (except for deferred retirements).

Chapter 94, P.L. 1997 requires the State Health Benefits Program to provide coverage for a minimum of 72 hours of inpatient care following a modified radical mastectomy and a minimum of 48 hours of inpatient care following a simple mastectomy. The law also provides that a carrier under the program shall not require

a health care provider to obtain authorization from the carrier for prescribing 72 or 48 hours, as appropriate, of inpatient care. The law shall not be construed to require a patient to receive inpatient care for 72 or 48 hours, as appropriate, if the patient in consultation with the patient's physician determines that a shorter length of stay is medically appropriate or relieve a patient or physician from any insurer notification requirements.

Chapter 330, P.L. 1997 provides health benefits to qualified retirees and their dependents (but not survivors), from the Police and Firemen's Retirement System (PFRS), the Consolidated Police and Firemen's Pension Fund (CPFPF), or the Public Employees' Retirement System (PERS) if the service was as a law enforcement officer or in a position eligible for participation in the PFRS. A qualified retiree is one who:

1. retires with 25 or more years of service or on a disability retirement;
2. retires from an employer who does not currently provide any payment or compensation toward the cost of health benefits to the retiree for any period of time;
3. was eligible to receive health benefits coverage at the expense of the employer immediately preceding retirement; and
4. has no other employer group coverage as an "employee" as a result of employment while retired.

The State pays 80% of the cost of coverage for the least expensive plan covering all 21 counties in the State. The retiree pays the rest. Qualified retirees are eligible regardless of whether the retiree's employer participated in the State Health Benefits Program.

Chapter 335, P.L. 1997 provides State paid health benefits to a retired State employee and any dependents (not including survivors), to employees who retire under the State Police Retirement System (SPRS) prior to January 12, 1998 with more than 20 but less than 25 years of service credit in the SPRS; were subsequently employed by the State in another position(s) not covered by the SPRS; and have in the aggregate, at least 30 years of full-time employment with the State. To be eligible the employee must be covered by the State Health Benefits Program at the time of terminating full-time employment with the State.

Chapter 338, P.L. 1997 requires hospital, medical and health service corporations, individual, small employer and large group insurers, health maintenance organizations and the New Jersey State Health Benefits Program (State Health Benefits Program) to provide coverage for the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods and low protein modified food products, when diagnosed and determined to be medically necessary by the covered person's physician. An "inherited metabolic disease" is defined as a disease caused by an inherited abnormality of body chemistry such as phenylketonuria (PKU). A "Low protein modified food product" is a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease, but does not include a natural food that is naturally low in protein; and "medical food" is a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed under direction of a physician.

Chapter 44, P.L. 1998 abolishes the Department of Commerce and Economic Development and creates the New Jersey Commerce and Economic Growth Commission. Section 7 of the bill states that employees of the commission shall be enrolled in the Public Employees' Retirement System and shall be eligible to participate in the State Health Benefits Program. The Commission can, however, elect to provide health benefits for its employees through private insurance policies, hospital and medical service corporations, HMOs, or any other manner available for the provision of health benefits, provided that the types of benefits do not provide less coverage than those benefits provided to other State employees.

Chapter 48, P.L. 1999 changes the way local employers participating in the State Health Benefits Program (State Health Benefits Program) can provide post-retirement health benefit coverage to its retired employees. The law makes the age and service eligibility requirements for employer payment of State Health Benefits Program health benefits coverage for retired employees the same as the requirements of N.J.S.40A:10-

23 currently applicable to local government employers that do not participate in State Health Benefits Program. The employer may, by filing a resolution with the Division of Pensions and Benefits, assume the cost of post retirement medical coverage for employees (and their dependents) who:

1. retired on a disability pension; or
2. retired with 25 or more years of service credit in a State or locally administered retirement system and a period of service of up to 25 years with the employer at the time of retirement, such period as established by the employer; or
3. retired and reached the age of 65 with 25 or more years of service credit in a State or locally administered retirement system and a period of service of up to 25 years with the employer at the time of retirement, such period as established by the employer; or
4. retired and reached age 62 with at least 15 years of service with the employer.

Further, the law provides that the employer payment obligations for retiree coverage may be determined by means of a collective negotiations agreement. With respect to employees for whom there is no majority representative for collective negotiations purposes, the employer may, in its sole discretion, determine the payment obligations for the employer and the employees, except that if there are collective negotiations agreements binding upon the employer for employees who are within the same community of interest as employees in a collective negotiations unit, the payment obligations shall be determined in a manner consistent with the terms of any collective negotiations agreement applicable to the collective negotiations unit. This provision applies to all local employers except an independent State authority, board, commission, corporation, agency or organization covered by Chapter 8, P. L. 1996, and school boards.

This law includes a grandfather provision which provides that the payment obligations of an employee for State Health Benefits Program coverage in retirement shall be the payment obligations applicable to the employee on the date the employee retires on a disability pension or the date the employee meets the age and service requirements for employer payment for the coverage, as the case may be.

Chapter 390, P.L. of 1999 impacts the insured managed care plans that participate in the State Health Benefits Program. This law requires carriers which offer managed care plans, including health maintenance organizations and preferred provider organizations and selective contracting arrangements offered by health insurance companies in the State, to provide for the continuation of treatment by a physician, under certain circumstances, in the event that the physician is no longer employed by the carrier.

Specifically, the law permits a covered person who is receiving post-operative follow-up care, oncological treatment, psychiatric treatment or obstetrical care by a physician who is employed by or under contract with a carrier at the time the treatment is initiated, to continue to be treated by that physician for the duration of the treatment in the event that the physician is no longer employed by or under contract with the carrier as follows:

(1) for a period not to exceed six months in the case of post-operative follow-up care;

(2) for a period not to exceed one year in the case of oncological treatment and psychiatric treatment; and

(3) through the duration of a pregnancy and up to six weeks after delivery in the case of obstetrical care.

The continuation of treatment by a particular physician shall be at the option of the covered person.

The law also provides that a carrier which offers a managed care plan shall provide in that plan for continued coverage of other health care services by a physician who was employed by or under contract with the carrier at the time the treatment was initiated, but is no longer employed by or under contract with the carrier, for up to 120 calendar days in cases where it is medically necessary for the covered person to continue treatment with that physician.

Health care benefits or services, as applicable, shall be provided by the health benefits plan for treatment of the specified conditions and any medically necessary treatment to the same extent as such ben-

efits or services were provided while the physician was employed by or under contract with the carrier. Reimbursement for the health care services shall be pursuant to the same fee schedule used to reimburse for the services when the physician was employed by or under contract with the carrier.

The law provides that a carrier shall not be liable for any inappropriate treatment provided to the covered person by a physician who is no longer employed by or under contract with the carrier. Also, the provisions of the law shall not apply to health care services provided by a physician who is the subject of disciplinary action by the State Board of Medical Examiners.

This law was approved on January 18, 2000.

Chapter 441, Public Law of 1999 requires that the State Health Benefits Commission provide the same coverage for biologically-based mental illness to persons covered under the State Health Benefits Program as that required for other health insurers and health maintenance organizations under P.L.1999, c.106.

Specifically, this law:

- requires that coverage be provided for biologically-based mental illness under the same terms and conditions as provided for any other sickness under the contract;
- defines "biologically-based mental illness" as a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism;
- defines "same terms and conditions" to mean that a health insurance carrier cannot apply different copayments, deductibles or benefit limits to biologically-based mental health benefits than those applied to other medical or surgical benefits;
- stipulates that its provisions shall not be construed to change the manner in which a health insurance carrier determines:
  a. whether a mental health care service meets the medical necessity standard as established by the carrier; or
  b. which health care providers shall be entitled to reimbursement for providing services for mental illness under the contract; and
- requires the State Health Benefits Commission to provide notice to employees regarding the coverage required by this bill in accordance with the provisions of the bill and regulations adopted by the Commissioner of Health and Senior Services.

The law clarifies that its provisions are an exception to the provisions in N.J.S.A.52:14-17.29, which provides for annual and lifetime caps on eligible expenses incurred because of mental illness or functional nervous disorders (a category which is broader than the biologically-based mental illnesses addressed in this law) that are lower than for major medical expense benefits.

This law was approved on January 18, 2000.

Chapter 126, P. L. of 2000 revises certain mandates, requirements and procedures that are burdensome on counties, municipalities and school districts. It also resolves certain administrative ambiguities and encourages more business-like practices on the part of local units in order to effectuate cost savings that will benefit property taxpayers. It is an omnibus piece of legislation, much of which is not related to pension or health benefit coverage.

Sections of the law impacting health benefits coverage are as follows:

Section 24: Amends N.J.S.A. 40A:10-6 to permit certain local units to establish health benefits funds for the provision of contributory or non-contributory self-funded or partially self-funded health benefits for employees or their dependents, or both. Boards of education, venture commissions, educational service commissions, county special services school districts, county vocational-technical schools, and county colleges are not included in the provision. Previously, the law only permitted local units to enter into

contracts for health insurance and was not clear whether local units could be self insured for health insurance without specific statutory authority. This provision validates local unit health benefits funds operating prior to the effective date of this law.

Section 25: Amends section 37 of P.L.1995, c.259 (N.J.S.A. 40A:10-17.1) to permit a county employee who receives health benefits as the dependent of his or her spouse, to waive health coverage under the county plan. Such persons could, at the discretion of the county, receive annually a payment from the county that does not exceed 50% of the county's savings because of the employee's waiver of coverage. Municipal employees received this right to waive coverage as a result of the enactment of P.L.1995, c.259.

This law was approved on September 21, 2000 and was effective immediately.

CHAPTER 189, P.L. 2001 extends to municipal authorities health benefit waiver provisions similar to those applicable to municipal employers under Chapter 259, P.L. 1995. Unlike Chapter 259, which applied to municipalities that participated in either the State Health Benefits Program or another group health plan, Chapter 189 only applies to municipal authorities that participate in the State Health Benefits Program.

The law pertains to any municipal authority created by a municipality under either the municipal sewerage authorities law, N.J.S.A.40:14A-1 et seq., or the municipal and county utilities authority law, N.J.S.A.40:14B-1 et seq. A municipal authority that participates in the State Health Benefits Program, may allow any employee who is eligible for coverage as a dependent of the employee's spouse under that program or under another health benefits plan offered by the spouse's employer, whether a public or private employer, to waive the State Health Benefits Program coverage to which the employee is entitled by virtue of employment with the municipal authority. In consideration of filing such a waiver, a municipal authority may pay to the employee annually an amount, to be established in the sole discretion of the authority, which shall not exceed 50% of the amount saved by the authority because of the employee's waiver of coverage. Under this law, an employee who waives coverage will be permitted to immediately resume coverage if the employee ceases to be covered through the employee's spouse for any reason, including, but not limited to, the retirement or death of the spouse or divorce. An employee who resumes coverage will repay, on a pro rata basis, any amount received from the municipal authority which represents an advance payment for a period of time during which coverage is resumed.

The law also provides that the decision of a municipal authority to allow its employees to waive State Health Benefits Program coverage and the amount of consideration to be paid therefor will not be subject to the collective bargaining process.

This law was approved on July 31, 2001 and was effective immediately.

Chapter 200, P.L. 2001 requires providers of most health benefits plans that include prescription drug coverage to issue to their insured members an identification card containing standardized pharmacy information.

The law applies to any health insurance carrier, multiple employer welfare arrangement or other health benefits plan provider, its agents (including any pharmacy benefits manager or third party administrator for a self-insured health benefits plan), that provides, administers or manages coverage for prescription drugs provided on an outpatient basis. The law explicitly does not apply to providers of Medicaid fee for service, Medicare supplemental insurance, disability income and long-term care plans, hospital indemnity insurance, and various other plans offering restricted health benefit coverage.

The law stipulates that the card shall comply with the standards set forth in the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide in effect at the time of card issuance or, at a minimum, contain the following information:

(1) the insured's identification number;

(2) the insured's name or, if the card is issued for another person included under the primary insured's coverage, that person's name;

(3) if required for proper claims adjudication,

- the name or identification number of the health benefits plan,
- the American National Standards Institute International Identification Number assigned to the plan's administrator or pharmacy benefits manager,
- the processor control number, and
- the insured's group number;

(4) the telephone number that providers may call for pharmacy benefits assistance; and

(5) any other information needed for proper claims adjudication, except for information required to be provided on the prescription.

The law directs a plan provider to issue each primary insured a new pharmacy identification card within 180 days after a change in the insured's coverage that changes the information required to be included on the card. The plan provider does not, however, have to issue a new card more than once in a calendar year.

The law provides that a plan provider need not issue a special pharmacy identification card to an insured who has already been issued a general plan member identification card containing the information required under the law. Also, it allows providers to use data elements that are required by State or federal regulations adopted under the federal "Health Insurance Portability and Accountability Act of 1996" ("HIPAA") in place of the information required under the law.

This law was approved August 8, 2001 and was effective on September 1, 2002.

Chapter 209, P.L. 2001 amends the statutes governing a retiree's eligibility for paid coverage under the State Health Benefits Program.

This law provides that instead of having to meet the 25-year service credit requirement for paid post-retirement medical coverage in a single State or locally-administered retirement system, a public employee under the State Health Benefits Program may receive this benefit if the 25 years of service credit is in one or more State or locally-administered retirement systems.

This law was approved August 15, 2001 and was effective immediately.

Chapter 227, P.L. 2001 clarifies the requirements of Chapter 415, P.L.1995, which requires health insurers that cover groups of 51 or more persons and HMOs to provide benefits for Pap smears. This law stipulates that the required health insurance coverage shall include coverage for any confirmatory test, when medically necessary and as ordered by the woman's physician, and all laboratory costs associated with the initial Pap smear and any such confirmatory test.

This law also requires the State Health Benefits Commission to provide these same benefits to each person covered under the State Health Benefits Program.

This law was approved August 27, 2001 and was effective immediately.

Chapter 284, P.L. 2001 requires the State Health Benefits Program to ensure that any person covered under the program who is enrolled in a health maintenance organization or the NJ PLUS, will be provided with 90-days notice if that person's primary care physician will be terminated from the provider network by the plan. If 90-days notice cannot be provided because the termination will occur prior to the end of the 90-day period, the health maintenance organization or NJ PLUS must notify the member as soon as the health maintenance organization or NJ PLUS has knowledge of the termination. Upon receiving such notification, the covered person shall be permitted to change coverage to another health benefits plan, even though the physician's termination may occur outside of the annual open enrollment period.

This law was approved on December 27, 2001 and was effective immediately.

Chapter 367, P.L. 2001 applies to health care carriers which offer a managed care plan that provides for both in-network and out-of-network benefits. It requires a carrier to reimburse a health care facility for the services provided by the facility at the carrier's full contracted rate without any penalty for the patient's selection of an out-of-network health care provider, in accordance with the in-network policies and in-

network copayment, coinsurance or deductible requirements of the managed care plan. This is so even if:

- a covered person is admitted by an out-of-network provider to an in-network health care facility for medically necessary health care services, or
- the covered person receives covered, medically necessary health care services from an out-of-network provider while the covered person is a patient at an in-network health care facility and was admitted to the health care facility by an in-network provider.

The law also amends the "Health Care Quality Act," N.J.S.A.26:2S-1 et seq., to require carriers which offer a managed care plan to disclose to subscribers, at the time of enrollment and annually thereafter, the carrier's preauthorization and review requirements of the health benefits plan regarding the determination of medical necessity that apply to a covered person who is admitted to an in-network health care facility, and the financial responsibility of the patient for the cost of services provided by an out-of-network admitting or attending health care practitioner.

The law applies to all policies and contracts issued or renewed on or after the date of enactment of the law.

Any contract purchased or renewed by the State Health Benefits Commission on or after the effective date of this Act, which provides hospital or medical expense benefits through a managed care plan, must meet the requirements of this law.

This law was approved on January 8, 2002 and was effective February 1, 2002..

The law also provides that the decision of a municipal authority to allow its employees to waive State Health Benefits Program coverage and the amount of consideration to be paid therefor will not be subject to the collective bargaining process.

This law was approved on January 8, 2002 and was effective February 1, 2002.

Chapter 23, P.L. 2002 Provides additional retirement benefits to eligible State employees and employees of State autonomous authorities who meet specified age and service requirements and who retire within a specified time period. State employees must retire on or after February 1, 2002, but no later than July 1, 2002. Employees of State autonomous authorities must retire on or after July 1, 2002, but no later than September 1, 2002 if the authority fiscal year ends on or before June 30, 2002. If the fiscal year ends after June 30, 2002, employees shall retire no earlier than two months before and not later than the first day of the calendar month after the close of the fiscal year. The offering of the additional retirement benefits is optional for the authorities.

The eligibility requirements and the additional benefits are as follows:

- Employees who are at least 50 years of age with at least 25 years of service credit under the Public Employees' Retirement System (PERS) or the Teachers' Pension and Annuity Fund (TPAF) will receive three additional years of service credit. Such members of the Alternate Benefit Program (ABP), federal Civil Service Retirement System (CSRS) or the Federal Employees Retirement System (FERS) will receive an amount equal to 60% of base annual salary. The amounts payable to members of the ABP and the federal systems will be paid in two separate installments.
- Employees who are at least 60 years of age with at least 20, but less than 25, years of service credit in PERS, TPAF or ABP, will receive payment by the retirement system or the State of retiree health care benefits on the same basis that the State currently pays for the coverage of retirees with 25 or more years of service credit. Authority employees already eligible for authority-paid health care benefits will receive $500 per month for 24 months, as will employees of authorities which do not offer employer-paid retiree health care coverage.
- Employees who are at least 60 years of age with at least 10, but not more than 20, years of service credit in PERS, TPAF or ABP, will receive an additional pension or payment of $500 a month for 24 months following the date of retirement.

- Employees who are at least 55 years of age with 25 or more years of service credit in PERS or TPAF and who retire on a veteran's retirement will receive an additional pension in the amount of 3/55 of the compensation upon which the retirement allowance is based.

Amounts payable to members of the ABP will be made to the employee's retirement annuity contract, up to the amount allowed by Section 415 of the Internal Revenue Code, and then to a contract on behalf of the employee that meets the requirements of Section 403(b) of the Code. Any amount in excess of the cumulative maximum contributions allowed under these Code provisions will be payable directly to the employee.

When the needs of State government, a college or university, or a State autonomous authority so require, an employee electing to retire under the law may continue in employment for up to one year with the approval of the employer and the agreement of the employee. If the employee dies during the period of continued employment, the retirement will become effective on the first day of the month after the date of death.

A State autonomous authority may elect to provide the benefits of this law by filing a resolution with the Division. A State autonomous authority which elects to offer the benefits provided by this law to its employees who are in PERS and which also has employees under other retirement systems or pension plans would be required to provide comparable benefits to those eligible employees.

The additional PERS and TPAF pension liabilities incurred by the State and electing State autonomous authorities will be added to their accrued liability and funded pursuant current pension laws governing unfunded accrued liabilities. Cash payments to ABP members will be made by the State colleges and universities.

The Director of the Division of Pensions and Benefits is required to report annually for five years to the Joint Budget Oversight Committee on the aggregate costs and savings resulting from the enactment of this substitute.

This law was effective on May 30, 2002.

Chapter 3, P.L. 2003 This law amends the statutes that allow a county, municipality, or contracting unit, as defined in the "Local Public Contracts Law" P.L. 1971 c. 198 (C. 40A:11-1 et seq.) that participates in the State Health Benefits Program or another group health benefits plan to allow an employee who is eligible for other health care coverage to waive coverage to which the employee is entitled as an employee of the county, municipality, or contracting unit.

The new law amends these statutes in two ways:

1. The ability to waiver is no longer limited to employees who have other coverage as a dependent of a spouse. It extends the waiver of coverage provisions to apply to any situation in which an employee is eligible for other health care coverage, and
2. The waiver provisions are extended to county colleges in the State Health Benefits Program or another group health benefits plan.

This law was effective January 27, 2003.

Chapter 27, P.L. 2003 This law requires:

- an employer that provides a health benefits plan to its employees or their dependents to provide 30 days' prior written notice to its employees if the plan is terminated, and
- a health insurer that increases premium rates upon the renewal of a health benefits plan to provide 60 days' prior written notice of the amount of a proposed increase to the employer that purchased the plans.

The provisions of this law apply to health benefits plans impacted by P.L. 1997, c. 192, otherwise known as the "Health Care Quality Act" (N.J.S.A. 26:2S-1 et seq.).

Although there is a question whether this law impacts the SHBP, the SHBP already meets or exceeds the

notification provisions of this law.

This law was effective May 9, 2003.

Chapter 71, P.L. 2003 This law provides for the addition of two members to the membership of the State Health Benefits Commission. The current members are the State Treasurer who serves as the Chairman, the Commissioner of Banking and Insurance and the Commissioner of Personnel.

One of the additional members will be a State employees' representative chosen by the Public Employees' Committee of the AFL-CIO; the other will be a representative chosen by the New Jersey Education Association.

This law was effective May 5, 2003.

Chapter 119, P.L. 2003 This law modifies the benefits of State employees under the New Jersey State Health Benefits Program (SHBP) and the New Jersey Employer-Employee Relations Act. The law provides that a State employee enrolled in SHBP on or after July 1, 2003 may not be eligible for coverage in the traditional plan pursuant to a binding collective negotiations agreement or pursuant to the application by the State Health Benefits Commission, in its sole discretion, of the terms of any collective negotiations agreement binding on the State to non-aligned State employees.

This law was effective July 1, 2003.

Chapter 127, P.L. 2003 This law provides additional retirement benefits to certain employees of a public agency or instrumentality, other than State agencies or instrumentalities, that elects to provide the benefits, who retire under the Public Employees' Retirement System (PERS). The governing body of the employer will have one year after the enactment of this law to adopt a resolution. Once a resolution is adopted and effective, employees will have three months to retire. These employers are authorities, boards, commissions, corporations and other agencies and instrumentalities participating in the PERS.

Employees who are at least 50 years of age and have at least 25 years of service credit as of the effective date of retirement will receive an additional three years of service credit. If the member is under age 55 at the time of retirement, the member's retirement allowance will not be reduced. Employees who satisfy age and service requirements and who retire on special veteran's retirement will receive an additional pension in the amount of 3/55 of the compensation upon which the retirement allowance is based.

Employees of employers that offer retirees paid health care benefits coverage who are at least 60 years of age with between 20 and 25 years of service as of the effective date of retirement will receive employer-paid post-retirement health care benefits coverage. Employees of employers that do not offer retirees paid health care benefits coverage who are at least 60 years of age and have at least 20 years of service as of the effective date of retirement will not be eligible for paid health care benefits coverage, but will receive an additional pension payment of $500 per month for the first 24 months after retirement. Employees who are at least 60 years of age with at least 10 but not more than 20 years of service credit as of the effective date of retirement will receive an additional pension of $500 per month for the first 24 months after retirement.

When the needs of an employer require the services of an employee who elects to retire and receive a benefit under this law, the employer, with the approval of the governing body and the consent of the employee, may delay the effective retirement date of the employee for up to one year. The delay authorized under the law does not extend the dates for qualification for benefits.

The cost of the enhanced PERS pension benefits will be funded by employer contributions to the retirement system and paid by the public agency or instrumentality that elects to participate. The additional pension liability shall be paid by each electing entity over a period of 15 years.

An employer may elect to provide these benefits by the adoption of a resolution by its governing body and the filing of a certified copy with the Director of the Division of Pensions and Benefits within three business days. The effective date of the resolution must fall within one year of enactment of this law. An employer may offer these benefits only once. An employer covered by this law must meet with the employ-

ee union representatives, whether or not the employer adopts a resolution, within a year of the enactment of this law.

The provisions of this law do not apply to employees of a public agency or organization that were eligible to participate in the State early retirement incentive program offered in 2002 pursuant to P.L. 2002, c.23.

This law also provides for the following:

- Partial purchase of pension service credit to qualify.
- The employer shall pay the cost of the actuarial work to determine the additional liability of the retirement systems for the benefits under this act, which shall be included in the initial contribution required from the employer.
- The promulgation of rules and regulations by the Division of Pensions and Benefits deemed necessary for the effective implementation of this act.
- Authorizes public agencies and instrumentalities to issue refunding bonds to retire the present value of the unfunded accrued pension liabilities for early retirement incentive benefits granted by the law.

This law was effective July 14, 2003.

Chapter 128, P.L. 2003 This law provides additional retirement benefits to certain employees of a county, a county college or a municipality that elect to provide the benefits, who retire under the Public Employees' Retirement System (PERS), the Teachers' Pension and Annuity Fund (TPAF) or the Alternate Benefit Program (ABP). The governing body of the employer will have one year after the enactment of this law to adopt a resolution electing to participate in this program. Once a resolution is adopted and effective, employees will have three months to retire. Employers participating in several locally administered county, municipal and school district pension systems may also adopt the provisions of this law.

Employees who are at least 50 years of age and have at least 25 years of service credit as of the effective date of retirement will receive an additional three years of service credit. If a member of PERS or TPAF is under age 55 at the time of retirement, the member's retirement allowance will not be reduced. Employees who satisfy age and service requirements and who retire on a special veteran's retirement will receive an additional pension in the amount of 3/55 of the compensation on which the retirement allowance is based. Participants in ABP will receive an amount equal to 100% of base annual salary at the time of retirement.

Employees who are at least 60 years of age with between 20 and 25 years of service as of the effective date of retirement will receive employer-paid coverage in the New Jersey State Health Benefits Program. The retired employees and their dependents will be eligible for coverage in the program even if the employer does not participate in the program or otherwise provide health care benefits coverage in retirement upon the normal retirement of such employees. Employees who are at least 60 years of age with between 10 and 20 years of service as of the effective date of retirement will receive an additional pension payment of $500 per month for the first 24 months after retirement.

When the needs of an employer require the services of an employee who elects to retire and receive a benefit under this law, the employer, with the approval of the governing body and the consent of the employee, may delay the effective retirement date of the employee for up to one year. The delay authorized under the law does not extend the dates for qualification for benefits.

The cost of the enhanced PERS and TPAF pension benefits will be funded by employer contributions to the retirement systems and paid by the county, county college or municipality who elect to participate. The additional pension liability shall be paid by each electing entity over a period of 15 years. Payments to ABP members shall be made by employers first to the members' annuity contract under the ABP, then to a member's section 403(b) contract, up to the limits allowed by the Internal Revenue Code. Payments in excess of any limits shall be paid directly to the member. The SHBP health care benefits payments for eligible retirees and their dependents will be paid by the employer on a current cost basis. Additionally, an electing county college employer shall be required to pay the SHBP health care premiums for three

years following retirement for each employee who retires under this program with 25 or more years of pension service credit and who would otherwise be qualified for State-paid health benefits after retirement.

An employer may elect to provide these benefits by the adoption of a resolution by its governing body and the filing of a certified copy with the Director of the Division of Pensions and Benefits within three business days. The effective date of the resolution must fall within one year of enactment of this law. An employer may offer these benefits only once. An employer covered by this law must meet with the employee union representatives, whether or not the employer adopts a resolution, within a year of the enactment of this law.

The provisions of this law do not apply to employees of a public agency or organization, nor does it apply to members of the Prosecutors Part of PERS.

This law also provides for the following:

- Partial purchase of pension service credit to qualify.
- The employer shall pay the cost of the actuarial work to determine the additional liability of the retirement systems for the benefits under this act, which shall be included in the initial contribution required from the employer.
- The promulgation of rules and regulations by the Division of Pensions and Benefits deemed necessary for the effective implementation of this act.
- The enrollment in the SHBP of those retiring under this act at age 60 with between 20 and 25 years of service within 60 days of retirement.
- Authorizes counties and municipalities to issue refunding bonds to retire the present value of the unfunded accrued pension liabilities for early retirement incentive benefits granted by the law.

This law was effective July 14, 2003.

Chapter 129, P.L. 2003 This law provides additional retirement benefits to certain employees of a local school board, educational services commission or jointure commission that elect to provide the benefits, who retire under the Public Employees' Retirement System (PERS) or the Teachers' Pension and Annuity Fund (TPAF). The governing body of the employer will have one year after the enactment of this law to adopt a resolution electing to participate in this program. Once a resolution is adopted and effective, employees will have two months to retire.

An employee who is at least 50 years of age and has at least 25 years of service credit under PERS or TPAF as of the effective date of retirement will receive an additional three years of service credit. If a member of PERS or TPAF is under age 55 at the time of retirement, the member's retirement allowance will not be reduced. An employee veteran who meets the age and service credit requirements and retires on a special veteran's retirement under PERS or TPAF will receive an additional pension in the amount of 3/55 of the compensation on which the retirement allowance is based.

An employee who is at least 60 years of age and has at least 20, but less than 25, years of service as of the effective date of retirement will receive full payment of premiums for coverage under the State Health Benefits Program (SHBP) for the retired employee and dependents, but not including survivors, whether or not the employer participates in SHBP with respect to its active employees. An employee who is at least 60 years of age with at least 10, but less than 20, years of service credit will receive an additional pension of $500 per month for the 24 months following retirement.

When the needs of an employer require the services of an employee who elects to receive a benefit under this law, the employer may delay, with the consent of the employee, the effective retirement date of the employee for up to one year. The authorization for a delay in the effective retirement date does not extend the dates for qualification for benefits.

The cost of the enhanced pension benefits will be funded by employer contributions to the retirement

systems and paid by the school boards, educational services commissions or jointure commissions who elect to participate. The additional pension liability shall be paid by each electing entity in level payments over a period of 15 years. The SHBP health care benefits payments for eligible retirees and their dependents will be paid by the employer on a current cost basis. Additionally, an electing employer shall be required to pay the SHBP health care premiums for each employee who retires under this program with 25 or mores years of pension service credit for three years following retirement.

An employer may elect to provide these benefits by the adoption of a resolution by its governing body, which is to be effective July 1, and the filing of a certified copy with the Director of the Division of Pensions and Benefits within three business days after its adoption. The effective date of the resolution must fall within 15 months of enactment of this law. An employer may offer these benefits only once. An employer covered by this law must meet with the employee union representatives, whether or not the employer adopts a resolution, within a year of the enactment of this law.

Any employee that was eligible, or could have been if the employer elected, to participate in the State early retirement incentive program offered in 2002 pursuant to P.L. 2002, c.23, is not eligible for the early retirement incentive benefits granted under this law.

This law also provides for the following:

- Partial purchase of pension service credit to qualify.
- The employer shall pay the cost of the actuarial work to determine the additional liability of the retirement systems for the benefits under this act which shall be included in the initial contribution required from the employer.
- The promulgation of rules and regulations by the Division of Pensions and Benefits deemed necessary for the effective implementation of this act.
- Authorizes boards of education to issue refunding bonds to retire the present value of the unfunded accrued pension liabilities for early retirement incentive benefits granted by the law.

This law was effective July 14, 2003.

Chapter 130, P.L. 2003 This law provides for additional retirement benefits for employees of an employer other than the State, that elects to offer the benefits, who retire under the Police and Firemen's Retirement System (PFRS). The governing body of the employer will have one year after the enactment of this law to adopt a resolution to offer the benefits. Once a resolution is adopted and effective, employees will have three months to retire.

Employees who have at least 25 years of service credit as of the effective date of retirement will receive an additional three years of service credit.

Employees who are at least 55 years of age with between 20 and 25 years of service as of the effective date of retirement will receive employer-paid coverage in the New Jersey State Health Benefits Program (SHBP). The retired employees, their dependents and survivors will be eligible for coverage in the program even if the employer does not participate in the SHBP or otherwise provide health care benefits coverage in retirement upon the normal retirement of such employees.

Employees who are at least 55 years of age with between 10 and 20 years of service as of the effective date of retirement will receive an additional pension payment of $500 per month for the first 24 months after retirement.

When the needs of an employer require the services of an employee who elects to retire and receive a benefit under this law, the employer, with the approval of the governing body and the consent of the employee, may delay the effective retirement date of the employee for up to one year. The delay authorized under the law does not extend the dates for qualification for benefits.

The cost of the enhanced PFRS pension benefits will be funded by employer contributions to the retirement systems and paid by the employers who elect to participate. The additional pension liability shall

be paid by each electing entity over a period of 15 years. The SHBP health care benefits payments for eligible retirees and their dependents will be paid by the employer on a current cost basis.

An employer may elect to provide these benefits by the adoption of a resolution by its governing body and the filing of a certified copy with the Director of the Division of Pensions and Benefits within three business days. The effective date of the resolution must fall within one year of enactment of this law. An employer may offer these benefits only once. An employer covered by this law must meet with the employee union representatives, whether or not the employer adopts a resolution, within a year of the enactment of this law.

This law also provides for the following:

- Partial purchase of pension service credit to qualify.
- The employer shall pay the cost of the actuarial work to determine the additional liability of the retirement systems for the benefits under this act, which shall be included in the initial contribution required from the employer.
- The promulgation of rules and regulations by the Division of Pensions and Benefits deemed necessary for the effective implementation of this act.
- The enrollment in the SHBP of those retiring under this act at age 55 with between 20 and 25 years of service within 60 days of retirement.
- Authorizes counties and municipalities to issue refunding bonds to retire the present value of the unfunded accrued pension liabilities for early retirement incentive benefits granted by the law.

This law was effective July 14, 2003.

Chapter 142, P.L. 2003 Provides health care benefits coverage through the State Health Benefits Program to members of the New Jersey National Guard, and their dependents, during the period when the member is called to State active duty by the Governor for at least 30 days within a 35 consecutive day period.

Benefits under the law are provided through enrollment in the State Health Benefits Program's NJ PLUS plan. The coverage would begin on the first day of active duty and end on the last day of such duty. It is available only if the member:

1. Is not a compensated, full-time appointed or elected public officer or employee of the State or any political subdivision thereof when called to active duty;
2. Had employer-provided health care benefits coverage that was canceled due to the member's military service or does not have employer-provided health care benefits coverage; and
3. Is not covered for health care benefits under a program, plan or policy as a dependent of the member's spouse when called to active duty.

The cost of coverage will be paid in full by the State.

Health care benefits coverage will be provided only if such coverage by the SHBP does not violate applicable federal statutes in a manner that would change the nature, governance, or status of the program.

This law was effective August 1, 2003

Chapter 172, P.L. 2003 Provides that a part-time State employee or a part-time faculty member, including part-time lecturers and adjunct faculty members, at a public institution of higher education in this State, who is enrolled in a State-administered retirement system, will be entitled to participate in the State Health Benefits Program and may purchase health benefits coverage in the State managed care plan under the State Health Benefits Program for the employee or faculty member, and the dependents of the employee or faculty member. If such an employee or faculty member elects to enroll and purchase coverage, the employee or faculty member will pay the full cost of the coverage. The employer will not be responsible for any costs in connection with the purchase of the coverage, unless the employer is obligated to pay all or a portion of such costs in accordance with the provisions of a binding collective negotiations agreement.

This law includes the following provisions:

- Part-time State employees and part-time faculty members will not qualify for employer or State-paid post-retirement health care benefits under the State Health Benefits Program, but that upon retirement, such employees and faculty members will be permitted to enroll in the State Health Benefits Program managed care plan they were enrolled in prior to retirement through the retired group at their own expense.
- The State Health Benefits Commission must advise eligible employees, and the public institutions of higher education must advise eligible faculty members, that they may enroll in the State Health Benefits Program and about any benefits to which they are entitled upon the termination of their employment.
- The State Health Benefits Commission may establish such rules and regulations necessary to enroll the persons covered by the law and to adopt procedures for the remittance to the program of the cost of coverage.
- A faculty member may enroll in the State Health Benefits Program only if the public institution of higher education that employs the faculty member participates in the program.

This law was effective on January 1, 2004.

Chapter 181, P.L. 2003 Provides that the eligibility of a surviving spouse to receive an accidental death benefit under the Police and Firemen's Retirement System (PFRS) or the State Police Retirement System (SPRS) shall not terminate upon remarriage.

Under the PFRS, when a member of the system dies in active service as a result of an accident met in the actual performance of duty, the surviving spouse is eligible to receive a survivorship benefit consisting of (i) a pension equal to 70% of the compensation upon which contributions by the member were based in the last year of creditable service, and (ii) State-paid coverage under the member's employer-sponsored health insurance plan. Under the SPRS, the corresponding accidental death benefit to the surviving spouse is a pension of 70% of the final compensation received by the member in the last 12 months of creditable service prior to death, plus the health benefit coverage.

Prior to the enactment of this law, under both the PFRS and SPRS, the surviving spouse ceased to be eligible for the accidental death benefit if he or she remarried. This law allows these surviving spouses to remarry without losing the benefit.

This law was effective on September 12, 2003.

Chapter 193, P.L. 2003 Establishes a Mandated Health Benefits Advisory Commission to study the social, financial, and medical impact of proposed mandated health benefits. Mandated health benefits are defined in this law as benefits or coverage that are required by law to be provided by a carrier and includes: coverage for specific health care services, treatments or practices; or direct reimbursement to specific health care providers.

This law was effective on November 21, 2003.

Chapter 308, P.L. 2003 Provides that if a member of the Legislature elects health benefits coverage on the basis of service in the Legislature, the member will not enroll as the primary insured for health benefits for which the member is eligible through any other public entity, and will not accept any amount of money in consideration for filing a waiver of coverage.

This law was effective on January 14, 2004.

Chapter 86, P.L. 2004 This law requires health insurers, including health, hospital and medical service corporations, commercial individual, small employer and group health insurers, health maintenance organizations and the State Health Benefits Program (SHBP), to provide health benefits coverage for expenses incurred in conducting a mammogram for women under 40 years of age who have a family history of breast cancer or other breast cancer risk factors, at such age and intervals as deemed medically necessary by the woman's health care provider.

The law also codifies in statute that the SHBP shall provide coverage for one baseline mammogram examination for women who are at least 35 but less than 40 years of age and a mammogram every year for women age 40 and over.

This act shall take effect on the 90th day after enactment and shall apply to all contracts and policies that are delivered, issued, executed or renewed or approved for issuance or renewal in this State on or after the effective date.

This law was effective October 5, 2004.

CHAPTER 135, P.L. 2005 Provides that an affiliate of a majority representative of State employees for collective negotiation purposes, which affiliate represents State employees, may obtain coverage in the State Health Benefits Program (SHBP) for its elected officers and employees and their dependents. As used in the law, the phrase "an affiliate of a majority representative of State employees" means a local union affiliate that has some employees who are engaged in the day-to-day representation of State employees, and does not mean a local union affiliate's parent or international union.

This law requires that on its effective date the Division of Pensions and Benefits in the Department of the Treasury must seek a determination letter from the federal Department of Labor confirming the status of the State Health Benefits Program as a qualified and exempt governmental plan under Title I of the federal Employee Retirement Income Security Act of 1974 (ERISA). In the event the division receives a determination letter from the federal Department of Labor stating that the law as embodied in this law changes the status of the State Health Benefits Program so that it is no longer a qualified and exempt governmental plan under Title I of ERISA, the law would be void and expire immediately and no employees of an affiliate of a majority representative of State employees for collective negotiation purposes would be permitted to newly enroll or continue to participate in the State Health Benefits Program.

This law was effective July 7, 2005, with union SHBP participation to begin 120 days hence.

CHAPTER 251, P.L. 2005 Requires health insurers that provide benefits for expenses incurred in the purchase of outpatient prescription drugs, to cover the cost of prescription female contraceptives. The provisions apply to hospital, medical and health service corporations, commercial individual, small employer and group health insurers, health maintenance organizations and prepaid prescription service organizations and the State Health Benefits Program.

This law took effect on the 180th day after enactment (July 3, 2006) and applies to policies and contracts issued or renewed on or after its effective date.

CHAPTER 334, P.L. 2005 Permits certain public entities that are not participating in the State Health Benefits Program (SHBP) to provide, at their option, dependent health benefits coverage to a person who is the domestic partner of an employee, pursuant to the "Domestic Partnership Act," N.J.S.A. 26:8A-1 et seq.

This law applies to entities such as municipalities, counties, local boards of education and county colleges whose employees are not enrolled in SHBP. Its provisions would allow these entities to voluntarily provide dependent health benefits coverage to an employee's domestic partner on the same basis as local public entities whose employees are enrolled in SHBP are already permitted to do under the "Domestic Partnership Act."to, or withdraw benefits from, an employee or dependents of an employee.

This law was effective March 13, 2006.

CHAPTER 375, P.L. 2005 This law requires health insurers to provide for an election of continued coverage by certain dependents, following the termination of dependent coverage at the time the dependents "age-out" of coverage, until their 30th birthday, under health benefits plans issued by health insurers, including hospital service corporations, medical service corporations, health service corporations, commercial insurers, health maintenance organizations and health benefits plans issued pursuant to the New Jersey Small Employer Health Benefits Program, and the New Jersey State Health Benefits Program. Nothing within the provisions of this law would require an employer to pay all or part of the cost of coverage for any election of this continued coverage.

This act shall take effect on the 120th day after enactment (May 12, 2006), and shall apply to all contracts, policies, or plans that are delivered, issued, executed or renewed, or approved for issuance or renewal in this State on or after the effective date.

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

STATE MONTHLY ACTIVE GROUP

RATES EFFECTIVE 1/1/2006 TO 12/31/2006

PROGRAM	DESCRIPTION OF COVERAGE	STATE CONTRIBUTION	MAXIMUM EMPLOYEE CONTRIBUTION*	TOTAL
NJ PLUS-#101	Single	$322.15	-------	$322.15
	Member & Spouse/Domestic Partner	$702.18	-------	$702.18
	Family	$835.77	-------	$835.77
	Parent & Child	$484.65	-------	$484.65
TRADITIONAL-#102	Single	$430.61	$143.53	$574.14
	Member & Spouse/Domestic Partner	$921.62	$307.20	$1,228.82
	Family	$1,096.88	$365.62	$1,462.50
	Parent & Child	$636.03	$212.00	$848.03
AETNA, INC.-#119	Single	$311.46	$16.39	$327.85
	Member & Spouse/Domestic Partner	$687.87	$36.20	$724.07
	Family	$800.05	$42.10	$842.15
	Parent & Child	$459.92	$24.20	$484.12
CIGNA HEALTHCARE-#120	Single	$363.10	$19.11	$382.21
	Member & Spouse/Domestic Partner	$792.04	$41.68	$833.72
	Family	$944.65	$49.71	$994.36
	Parent & Child	$545.06	$28.68	$573.74
OXFORD-#128	Single	$324.76	$17.09	$341.85
	Member & Spouse/Domestic Partner	$714.39	$37.59	$751.98
	Family	$844.27	$44.43	$888.70
	Parent & Child	$487.15	$25.63	$512.78
AMERIHEALTH-#133	Single	$351.86	$18.51	$370.37
	Member & Spouse/Domestic Partner	$782.88	$41.20	$824.08
	Family	$911.72	$47.98	$959.70
	Parent & Child	$519.44	$27.33	$546.77
HEALTH NET-#134	Single	$357.06	$18.79	$375.85
	Member & Spouse/Domestic Partner	$777.80	$40.93	$818.73
	Family	$944.19	$49.69	$993.88
	Parent & Child	$547.75	$28.82	$576.57
PRESCRIPTION DRUG PROGRAM-#202	Single	$115.96	-------	$115.96
	Member & Spouse/Domestic Partner	$265.03	-------	$265.03
	Family	$278.38	-------	$278.38
	Parent & Child	$154.76	-------	$154.76

* Employee contribution: Traditional = 25%; HMOs = 5%.

** Traditional Plan deductible $250, NJ PLUS and HMO office visit copay $10

(FOR EMPLOYERS **WITHOUT** A PRESCRIPTION DRUG PLAN)

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

LOCAL MONTHLY ACTIVE GROUP - EDUCATION EMPLOYERS

RATES EFFECTIVE 1/1/2006 TO 12/31/2006

PROGRAM	DESCRIPTION OF COVERAGE	EMPLOYER SINGLE COST	DEPENDENT COST	TOTAL
NJ PLUS-#001	Single	$345.70	-------	$345.70
	Member & Spouse/Domestic Partner	$346.87	$422.53	$769.40
	Family	$347.29	$547.91	$895.20
	Parent & Child	$346.21	$164.25	$510.46
TRADITIONAL-#002	Single	$542.83	-------	$542.83
	Member & Spouse/Domestic Partner	$544.00	$634.37	$1,178.37
	Family	$544.42	$834.53	$1,378.95
	Parent & Child	$543.34	$246.45	$789.79
AETNA, INC.-#019	Single	$437.44	-------	$437.44
	Member & Spouse/Domestic Partner	$438.61	$507.63	$946.24
	Family	$439.03	$625.61	$1,064.64
	Parent & Child	$437.95	$161.66	$599.61
CIGNA HEALTHCARE-#020	Single	$509.65	-------	$509.65
	Member & Spouse/Domestic Partner	$510.82	$583.76	$1,094.58
	Family	$511.24	$749.99	$1,261.23
	Parent & Child	$510.16	$204.22	$714.38
OXFORD-#028	Single	$400.98	-------	$400.98
	Member & Spouse/Domestic Partner	$402.15	$479.90	$882.05
	Family	$402.57	$639.86	$1,042.43
	Parent & Child	$401.49	$199.96	$601.45
AMERIHEALTH-#033	Single	$509.13	-------	$509.13
	Member & Spouse/Domestic Partner	$510.30	$622.55	$1,132.85
	Family	$510.72	$808.53	$1,319.25
	Parent & Child	$509.64	$241.95	$751.59
HEALTH NET-#034	Single	$481.15	-------	$481.15
	Member & Spouse/Domestic Partner	$482.32	$565.83	$1,048.15
	Family	$482.74	$789.65	$1,272.39
	Parent & Child	$481.66	$256.49	$738.15

(FOR EMPLOYERS **WITH** A PRESCRIPTION DRUG PLAN)

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

LOCAL MONTHLY ACTIVE GROUP - EDUCATION EMPLOYERS

RATES EFFECTIVE 1/1/2006 TO 12/31/2006

PROGRAM	DESCRIPTION OF COVERAGE	EMPLOYER SINGLE COST	DEPENDENT COST	TOTAL
NJ PLUS-#001	Single	$309.74	-------	$309.74
	Member & Spouse/Domestic Partner	$310.91	$378.44	$689.35
	Family	$311.33	$490.75	$802.08
	Parent & Child	$310.25	$147.11	$457.36
TRADITIONAL-#002	Single	$454.19	-------	$454.19
	Member & Spouse/Domestic Partner	$455.36	$535.20	$990.56
	Family	$455.78	$702.10	$1,157.88
	Parent & Child	$454.70	$207.90	$662.60
AETNA, INC.-#019	Single	$319.71	-------	$319.71
	Member & Spouse/Domestic Partner	$320.88	$385.19	$706.07
	Family	$321.30	$499.92	$821.22
	Parent & Child	$320.22	$151.86	$472.08
CIGNA HEALTHCARE-#020	Single	$388.53	-------	$388.53
	Member & Spouse/Domestic Partner	$389.70	$457.79	$847.49
	Family	$390.12	$620.66	$1,010.78
	Parent & Child	$389.04	$194.17	$583.21
OXFORD-#028	Single	$332.77	-------	$332.77
	Member & Spouse/Domestic Partner	$333.94	$398.08	$732.02
	Family	$334.36	$530.75	$865.11
	Parent & Child	$333.28	$165.89	$499.17
AMERIHEALTH-#033	Single	$357.10	-------	$357.10
	Member & Spouse/Domestic Partner	$358.27	$436.31	$794.58
	Family	$358.69	$566.66	$925.35
	Parent & Child	$357.61	$169.58	$527.19
HEALTH NET-#034	Single	$367.74	-------	$367.74
	Member & Spouse/Domestic Partner	$368.91	$432.16	$801.07
	Family	$369.33	$603.11	$972.44
	Parent & Child	$368.25	$195.87	$564.12
PRESCRIPTION DRUG PROGRAM-#201	Single	$131.53	-------	$131.53
	Member & Spouse/Domestic Partner	$131.53	$169.16	$300.69
	Family	$131.53	$184.62	$316.15
	Parent & Child	$131.53	$44.08	$175.61

(FOR EMPLOYERS **WITHOUT** A PRESCRIPTION DRUG PLAN)

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

LOCAL MONTHLY ACTIVE GROUP - LOCAL GOVERNMENT EMPLOYERS

(EXCLUDES EDUCATION EMPLOYERS)

RATES EFFECTIVE 1/1/2006 TO 12/31/2006

PROGRAM	DESCRIPTION OF COVERAGE	EMPLOYER SINGLE COST	DEPENDENT COST	TOTAL
NJ PLUS-#001	Single	$399.34	-------	$399.34
	Member & Spouse/Domestic Partner	$400.51	$488.26	$888.77
	Family	$400.93	$633.17	$1,034.10
	Parent & Child	$399.85	$189.82	$589.67
TRADITIONAL-#002	Single	$570.28	-------	$570.28
	Member & Spouse/Domestic Partner	$571.45	$666.57	$1,238.02
	Family	$571.87	$876.91	$1,448.78
	Parent & Child	$570.79	$258.94	$829.73
AETNA, INC.-#019	Single	$437.44	-------	$437.44
	Member & Spouse/Domestic Partner	$438.61	$507.63	$946.24
	Family	$439.03	$625.61	$1,064.64
	Parent & Child	$437.95	$161.66	$599.61
CIGNA HEALTHCARE-#020	Single	$509.65	-------	$509.65
	Member & Spouse/Domestic Partner	$510.82	$583.76	$1,094.58
	Family	$511.24	$749.99	$1,261.23
	Parent & Child	$510.16	$204.22	$714.38
OXFORD-#028	Single	$400.98	-------	$400.98
	Member & Spouse/Domestic Partner	$402.15	$479.90	$882.05
	Family	$402.57	$639.86	$1,042.43
	Parent & Child	$401.49	$199.96	$601.45
AMERIHEALTH-#033	Single	$509.13	-------	$509.13
	Member & Spouse/Domestic Partner	$510.30	$622.55	$1,132.85
	Family	$510.72	$808.53	$1,319.25
	Parent & Child	$509.64	$241.95	$751.59
HEALTH NET-#034	Single	$481.15	-------	$481.15
	Member & Spouse/Domestic Partner	$482.32	$565.83	$1,048.15
	Family	$482.74	$789.65	$1,272.39
	Parent & Child	$481.66	$256.49	$738.15

(FOR EMPLOYERS **WITH** A PRESCRIPTION DRUG PLAN)

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

LOCAL MONTHLY ACTIVE GROUP - LOCAL GOVERNMENT EMPLOYERS
(EXCLUDES EDUCATION EMPLOYERS)

RATES EFFECTIVE 1/1/2006 TO 12/31/2006

PROGRAM	DESCRIPTION OF COVERAGE	EMPLOYER SINGLE COST	DEPENDENT COST	TOTAL
NJ PLUS-#001	Single	$354.71	-------	$354.71
	Member & Spouse/Domestic Partner	$355.88	$433.62	$789.50
	Family	$356.30	$562.29	$918.59
	Parent & Child	$355.22	$168.56	$523.78
TRADITIONAL-#002	Single	$488.03	-------	$488.03
	Member & Spouse/Domestic Partner	$489.20	$575.22	$1,064.42
	Family	$489.62	$754.60	$1,244.22
	Parent & Child	$488.54	$223.49	$712.03
AETNA, INC.-#019	Single	$319.71	-------	$319.71
	Member & Spouse/Domestic Partner	$320.88	$385.19	$706.07
	Family	$321.30	$499.92	$821.22
	Parent & Child	$320.22	$151.86	$472.08
CIGNA HEALTHCARE-#020	Single	$388.53	-------	$388.53
	Member & Spouse/Domestic Partner	$389.70	$457.79	$847.49
	Family	$390.12	$620.66	$1,010.78
	Parent & Child	$389.04	$194.17	$583.21
OXFORD-#028	Single	$332.77	-------	$332.77
	Member & Spouse/Domestic Partner	$333.94	$398.08	$732.02
	Family	$334.36	$530.75	$865.11
	Parent & Child	$333.28	$165.89	$499.17
AMERIHEALTH-#033	Single	$357.10	-------	$357.10
	Member & Spouse/Domestic Partner	$358.27	$436.31	$794.58
	Family	$358.69	$566.66	$925.35
	Parent & Child	$357.61	$169.58	$527.19
HEALTH NET-#034	Single	$367.74	-------	$367.74
	Member & Spouse/Domestic Partner	$368.91	$432.16	$801.07
	Family	$369.33	$603.11	$972.44
	Parent & Child	$368.25	$195.87	$564.12
PRESCRIPTION DRUG PROGRAM-#201	Single	$131.53	-------	$131.53
	Member & Spouse/Domestic Partner	$131.53	$169.16	$300.69
	Family	$131.53	$184.62	$316.15
	Parent & Child	$131.53	$44.08	$175.61

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

DENTAL PROGRAM
STATE MONTHLY ACTIVE GROUP

RATES EFFECTIVE 1/1/2006 TO 12/31/2006

PROGRAM	DESCRIPTION OF COVERAGE	STATE CONTRIBUTION	EMPLOYEE CONTRIBUTION	TOTAL
DENTAL EXPENSE PLAN - #399	SINGLE	$20.67	$20.67	$41.34
	Member & Spouse/Domestic Partner	$35.91	$35.92	$71.83
	FAMILY	$58.76	$58.77	$117.53
	PARENT & CHILD	$43.53	$43.53	$87.06
DENTAL PROVIDER ORGANIZATIONS (DPO) HEALTHPLEX (DPO #307) FORTIS (DPO #308) FLAGSHIP HEALTH SYSTEMS, INC. (DPO #312) HORIZON DENTAL CHOICE (DPO #317)				
	SINGLE	$10.34	$10.33	$20.67
	Member & Spouse/Domestic Partner	$17.84	$18.07	$35.91
	FAMILY	$29.31	$29.44	$58.75
	PARENT & CHILD	$21.87	$21.65	$43.52
BENECARE (DPO #301)	SINGLE	$14.00	$10.33	$24.33
	Member & Spouse/Domestic Partner	$24.19	$18.07	$42.26
	FAMILY	$39.72	$29.44	$69.16
	PARENT & CHILD	$29.58	$21.65	$51.23
COMMUNITY DENTAL (DPO #302)	SINGLE	$12.88	$10.33	$23.21
	Member & Spouse/Domestic Partner	$22.29	$18.07	$40.36
	FAMILY	$36.57	$29.44	$66.01
	PARENT & CHILD	$27.24	$21.65	$48.89
CIGNA (DPO #305)	SINGLE	$10.84	$10.33	$21.17
	Member & Spouse/Domestic Partner	$18.74	$18.07	$36.81
	FAMILY	$30.77	$29.44	$60.21
	PARENT & CHILD	$22.97	$21.65	$44.62
GROUP DENTAL HEALTH ADMINISTRATORS (DPO #306)	SINGLE	$10.73	$10.33	$21.06
	Member & Spouse/Domestic Partner	$18.52	$18.07	$36.59
	FAMILY	$30.44	$29.44	$59.88
	PARENT & CHILD	$22.71	$21.65	$44.36
DENTAL GROUP OF NEW JERSEY, INC. (DPO#314)	SINGLE	$8.98	$10.33	$19.31
	Member & Spouse/Domestic Partner	$15.52	$18.07	$33.59
	FAMILY	$25.49	$29.44	$54.93
	PARENT & CHILD	$19.05	$21.65	$40.70
AETNA DMO (DPO #319)	SINGLE	$9.81	$10.33	$20.14
	Member & Spouse/Domestic Partner	$16.96	$18.07	$35.03
	FAMILY	$27.87	$29.44	$57.31
	PARENT & CHILD	$20.82	$21.65	$42.47

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

DENTAL PROGRAM

LOCAL MONTHLY ACTIVE GROUP - LOCAL GOVERNMENT AND EDUCATION EMPLOYERS

RATES EFFECTIVE 1/1/2006 TO 12/31/2006

PROGRAM	DESCRIPTION OF COVERAGE	TOTAL*
DENTAL EXPENSE PLAN - #399	SINGLE	$41.34
	Member & Spouse/Domestic Partner	$71.83
	FAMILY	$117.53
	PARENT & CHILD	$87.06
DENTAL PROVIDER ORGANIZATIONS (DPO)		
HEALTHPLEX (DPO #307)		
FORTIS (DPO #308)		
FLAGSHIP HEALTH SYSTEMS, INC. (DPO #312)		
HORIZON DENTAL CHOICE (DPO #317)		
	SINGLE	$20.67
	Member & Spouse/Domestic Partner	$35.91
	FAMILY	$58.75
	PARENT & CHILD	$43.52
BENECARE (DPO #301)	SINGLE	$24.33
	Member & Spouse/Domestic Partner	$42.26
	FAMILY	$69.16
	PARENT & CHILD	$51.23
COMMUNITY DENTAL (DPO #302)	SINGLE	$23.21
	Member & Spouse/Domestic Partner	$40.36
	FAMILY	$66.01
	PARENT & CHILD	$48.89
CIGNA (DPO #305)	SINGLE	$21.17
	Member & Spouse/Domestic Partner	$36.81
	FAMILY	$60.21
	PARENT & CHILD	$44.62
GROUP DENTAL HEALTH ADMINISTRATORS (DPO #306)	SINGLE	$21.06
	Member & Spouse/Domestic Partner	$36.59
	FAMILY	$59.88
	PARENT & CHILD	$44.36
DENTAL GROUP OF NEW JERSEY, INC. (DPO#314)	SINGLE	$19.31
	Member & Spouse/Domestic Partner	$33.59
	FAMILY	$54.93
	PARENT & CHILD	$40.70
AETNA DMO (DPO #319)	SINGLE	$20.14
	Member & Spouse/Domestic Partner	$35.03
	FAMILY	$57.31
	PARENT & CHILD	$42.47

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

STATE RETIRED GROUP

RATES EFFECTIVE 1/1/2006 TO 12/31/2006

Description	NJ PLUS (001)	Traditional (002)	Aetna, Inc. (019)	Cigna Healthcare (020)	Oxford (028)	Amerihealth (033)	Health Net (034)
Single — No Medicare	$683.56	$790.04	$459.99	$514.20	$422.44	$541.53	$504.35
Single — On Medicare	$433.88	$384.39	$410.83	$416.68	$347.80	$437.40	$377.25
Member & Spouse/Partner — No Medicare	$1,489.92	$1,691.01	$995.02	$1,104.37	$929.27	$1,204.94	$1,098.69
Member & Spouse/Partner — One on Medicare	$1,117.44	$1,174.43	$870.82	$930.88	$770.24	$978.93	$881.60
Member & Spouse/Partner — Both on Medicare	$867.67	$768.81	$821.70	$833.40	$695.62	$874.83	$754.53
Family — No Medicare	$1,773.43	$2,012.61	$1,119.52	$1,272.51	$1,098.24	$1,403.21	$1,333.74
Family — One on Medicare	$1,400.95	$1,496.03	$995.32	$1,099.02	$939.21	$1,177.20	$1,116.65
Family — Both on Medicare	$1,121.95	$1,035.88	$970.80	$1,021.20	$895.46	$1,109.39	$984.60
Parent & Child — No Medicare	$1,028.37	$1,167.00	$630.51	$720.77	$633.65	$799.42	$773.75
Parent & Child — Retiree on Medicare	$767.04	$739.91	$581.35	$664.56	$559.01	$688.27	$640.63

NEW JERSEY STATE HEALTH BENEFITS PROGRAM
LOCAL RETIRED GROUP - EDUCATION EMPLOYERS
RATES EFFECTIVE 1/1/2006 TO 12/31/2006

Description	NJ PLUS (001)	Traditional (002)	Aetna, Inc. (019)	Cigna Healthcare (020)	Oxford (028)	Amerihealth (033)	Health Net (034)
Single — No Medicare	$610.62	$722.15	$437.44	$509.65	$400.98	$509.13	$481.15
Single — On Medicare	$365.08	$357.78	$392.72	$411.11	$327.71	$411.36	$364.27
Member & Spouse/Partner — No Medicare	$1,359.18	$1,572.86	$946.24	$1,094.58	$882.05	$1,132.85	$1,048.15
Member & Spouse/Partner — One on Medicare	$975.70	$1,079.93	$830.16	$920.76	$728.69	$920.49	$845.42
Member & Spouse/Partner — Both on Medicare	$730.18	$715.60	$785.47	$822.26	$655.44	$822.75	$728.56
Family — No Medicare	$1,581.37	$1,839.15	$1,064.64	$1,261.23	$1,042.43	$1,319.25	$1,272.39
Family — One on Medicare	$1,197.89	$1,346.22	$948.56	$1,087.41	$889.07	$1,106.89	$1,069.66
Family — Both on Medicare	$926.75	$932.23	$928.00	$1,007.55	$843.73	$1,043.34	$950.70
Parent & Child — No Medicare	$901.68	$1,052.72	$599.61	$714.38	$601.45	$751.59	$738.15
Parent & Child — Retiree on Medicare	$634.88	$649.52	$554.89	$615.84	$544.48	$653.82	$621.27

NEW JERSEY STATE HEALTH BENEFITS PROGRAM
LOCAL RETIRED GROUP - LOCAL GOVERNMENT EMPLOYERS (EXCLUDES EDUCATION)
RATES EFFECTIVE 1/1/2006 TO 12/31/2006

Description	NJ PLUS (001)	Traditional (002)	Aetna, Inc. (019)	Cigna Healthcare (020)	Oxford (028)	Amerihealth (033)	Health Net (034)
Single — No Medicare	$613.81	$832.84	$437.44	$509.65	$400.98	$509.13	$481.15
Single — On Medicare	$368.99	$379.90	$392.72	$411.11	$327.71	$411.36	$364.27
Member & Spouse/Partner — No Medicare	$1,366.29	$1,814.05	$946.24	$1,094.58	$882.05	$1,132.85	$1,048.15
Member & Spouse/Partner — One on Medicare	$982.80	$1,212.74	$830.16	$920.76	$728.69	$920.49	$845.42
Member & Spouse/Partner — Both on Medicare	$737.99	$759.69	$785.47	$822.26	$655.44	$822.75	$728.56
Family — No Medicare	$1,589.64	$2,121.19	$1,064.64	$1,261.23	$1,042.43	$1,319.25	$1,272.39
Family — One on Medicare	$1,206.15	$1,519.88	$948.56	$1,087.41	$889.07	$1,106.89	$1,069.66
Family — Both on Medicare	$936.66	$1,011.00	$928.00	$1,007.55	$843.73	$1,043.34	$950.70
Parent & Child — No Medicare	$906.39	$1,214.17	$599.61	$714.38	$601.45	$751.59	$738.15
Parent & Child — Retiree on Medicare	$638.21	$709.68	$554.89	$615.84	$544.48	$653.82	$621.27

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

DENTAL PROGRAM
STATE RETIREE GROUP

RATES EFFECTIVE 1/1/2006 TO 12/31/2006

PROGRAM	DESCRIPTION OF COVERAGE	MONTHLY RETIREE RATE
RETIREE DENTAL EXPENSE PLAN - #398	SINGLE	$35.53
	Member & Spouse/Domestic Partner	$70.10
	FAMILY	$91.34
	PARENT & CHILD	$52.83

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

DENTAL PROGRAM
RETIREE GROUP - LOCAL GOVERNMENT

RATES EFFECTIVE 1/1/2006 TO 12/31/2006

PROGRAM	DESCRIPTION OF COVERAGE	MONTHLY RETIREE RATE
RETIREE DENTAL EXPENSE PLAN - #398	SINGLE	$35.53
	Member & Spouse/Domestic Partner	$70.10
	FAMILY	$91.34
	PARENT & CHILD	$52.83

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

DENTAL PROGRAM
RETIREE GROUP - LOCAL EDUCATION

RATES EFFECTIVE 1/1/2006 TO 12/31/2006

PROGRAM	DESCRIPTION OF COVERAGE	MONTHLY RETIREE RATE
RETIREE DENTAL EXPENSE PLAN - #398	SINGLE	$35.53
	Member & Spouse/Domestic Partner	$70.10
	FAMILY	$91.34
	PARENT & CHILD	$52.83

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