CHAPTER 9

STATE HEALTH BENEFITS PROGRAM

Authority

N.J.S.A. 52:14–17.27.

Source and Effective Date

R.2003 d.437, effective October 9, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).

Chapter Expiration Date

Chapter 9, State Health Benefits Program, expires on October 9, 2008.

Chapter Historical Note

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

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

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

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

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

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

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

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

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

Subchapter 9, Dental Expense Program, was formerly codified at N.J.A.C. 17:1–11 (Chapter 1) and adopted as R.1978 d.99, effective March 15, 1978. See: 10 N.J.R. 38(b), 10 N.J.R. 175(d).

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

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

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

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

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

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

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

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

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

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

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

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

Subchapter 9, Dental Expense Programs, was recodified by R.1993 d.268, effective August 2, 1993. See: 25 N.J.R. 675(b), 25 N.J.R. 3506(b).

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

Pursuant to Executive Order No. 66(1978), Chapter 9, State Health Benefits Program, was readopted as R.1998 d.406, effective July 13, 1998. See: 30 N.J.R. 1919(a), 30 N.J.R. 2953(a).

Chapter 9, State Health Benefits Program, was readopted as R.2003 d.437, effective October 9, 2003. See: Source and Effective Date. See, also, section annotations.

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State Health Benefits Program. Judith Nallin, 134 N.J.L.J. No. 3, 61 (1993).

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SUBCHAPTER 1. ADMINISTRATION

17:9–1.1 Commission meetings

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

(b) Any three members of the Commission, at least two of whom are ex-officio members, shall constitute a quorum for the purpose of conducting the business of the Commission. Each member shall be entitled to one vote and a majority of all votes of the entire Commission shall be necessary for a motion to carry.

(c) If a member is unable to attend a meeting, the member, if an ex-officio member, or the Public Employees' Committee of the AFL–CIO or the New Jersey Education Association shall designate, in writing, an alternate. The person so designated shall be permitted to vote on business brought before the Commission.

(d) All Commission members and alternates shall complete mandatory training required by the implementing regulations of the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) prior to hearing any appeals before the Commission.

Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
In (a), substituted "Chairperson" for "chairman"; in (c), rewrote the first sentence.
Amended by R.2004 d.21, effective January 20, 2004.
See: 35 N.J.R. 3745(a), 36 N.J.R. 440(a).
Rewrote (b); in (c), rewrote the first sentence; added (d).

17:9–1.2 Records

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

(b) Pursuant to P.L. 1997, c.330 (N.J.S.A. 52:14–17.32i et seq.), a qualified retiree and his or her eligible dependents, as defined in section 2 of P.L. 1961, c.49 (N.J.S.A. 52:14–17.26), but not survivors, are eligible to participate in the State Health Benefits Program (SHBP) in accordance with the laws and rules governing the program, regardless of whether the retiree's employer participated in the program, and for State payment of an amount of the premium or periodic charges for the category of coverage elected by the qualified retiree equal to 80 percent of the premium or periodic charges for that category of coverage under the State managed care plan or health maintenance organization which provides services in the 21 counties of the State and the lower premium or periodic charges.

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

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

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

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

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

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

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

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

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

New Rule, R.1999 d.373, effective November 1, 1999.
See: 31 N.J.R. 2300(b), 31 N.J.R. 3524(b).
Amended by R.2000 d.495, effective December 18, 2000.
See: 32 N.J.R. 3387(a), 32 N.J.R. 4451(a).
In (a)1, rewrote iii.
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote (c); added (e).

17:9–6.10 Retiree prescription drug card plan

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

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

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

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

"Preferred brands" means brand name prescription drug products and insulin determined by the provider, to be more

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

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

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

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

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

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

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

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

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

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

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

(g) The amount of out-of-pocket expense that a retired member or eligible dependent shall pay for a calendar year for eligible prescription drug expenses under the card plan shall be limited initially for calendar years 2000 and 2001 to $300.00.

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

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

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

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

1. To limit excessive annual increases which are significantly higher than the trends for the increases over the preceding five years;

2. To maintain an appropriate spread between the categories of co-payment amounts; or

3. To prevent undue hardship to retirees if general economic circumstances in the State or economic circumstances relative to health care for retirees are such that strict application of the formulas for the annual increases in the co-payments or the maximum out-of-pocket expense would produce such hardship.

New Rule R.2000 d.116, effective March 20, 2000.
See: 31 N.J.R. 4235(a), 32 N.J.R. 1048(a).
Notice of increase in co-payments and maximum out-of-pocket expenses, effective January 1, 2002.
See: 33 N.J.R. 3774(a).
Public Notice: Notice of increase in co-payments and out-of-pocket expenses, effective January 1, 2004.
See: 35 N.J.R. 4791(b).
Public Notice: Notice of increase in the amounts of co-payments and the maximum out-of-pocket expenses under the retiree prescription drug card plan.
See: 37 N.J.R. 363(b).

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

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

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

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

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

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

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

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

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

New Rule, R.2003 d.185, effective May 5, 2003.
See: 35 N.J.R. 87(a), 35 N.J.R. 1925(a).

SUBCHAPTER 7. TERMINATION

17:9–7.1 Termination effective date

(a) Cessation of active SHBP employee coverage shall be deemed to occur on the last day of eligibility for the coverage period for which charges have been paid.

(b) If a SHBP subscriber does not remit payment by the end of the month in which payment is due and owing, the SHBP shall notify the member by regular mail that the right to continue coverage will be suspended if payment in full is not remitted within 30 days of the suspension notice. If no payment is made, the SHBP shall generate a notice of termination to the member indicating the termination date and restating the amounts due to reinstate coverage. Termination shall be effective on the last day of the month for which premiums were paid. The SHBP shall not reinstate the member unless the member remits the entire balance due. Once coverage terminates, reinstatement is not automatic and will only be done after a review of the individual's circumstances by the SHBP.

(c) Cessation of SHBP coverage for a member who is awaiting approval of a retirement benefit shall not occur if the retiring member agrees, in writing, to the deduction of any retroactive SHBP premiums owed by the subscriber from the retirement benefit when approved, the withdrawal check, or the return of pension contributions.

As amended, R.1983 d.44, eff. March 7, 1983.
See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).
The word "premiums" was changed to "charges".
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.

17:9–7.2 Termination of eligibility

(a) The coverage of an employee and such employee's eligible dependents shall terminate whenever such employee's eligibility shall cease for any of the reasons given in (c) below.

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

(c) Coverage for the employee and the employee's dependents will terminate if:

1. The subscriber voluntarily terminates coverage;

2. The employee terminates employment;

3. The employee's hours are reduced so the employee no longer qualifies for coverage as a full-time employee. An employee whose coverage terminated as a result of a change from full-time to part-time status cannot be reenrolled until the employee has reestablished eligibility for coverage by serving the normal waiting period prescribed for new enrollees. In no event will the waiting period include any part-time service rendered by the employee;

4. The employee is on a leave of absence and the employee does not make required premium payments. The coverage of an eligible employee and of an employee's dependents during any period of authorized leave of absence without pay shall terminate on the last day of the second coverage period following the last payroll period or month for which the employee received a salary payment if the total charge for the coverage is not paid by the employee;

5. The employee enters the Armed Forces, is eligible for government-sponsored health services and is not receiving differential pay from the State or local employer;

6. The subscriber's employer ceases to participate in the SHBP;

7. The subscriber dies;

8. The employee is suspended; or

9. The employee is on a furlough or extended furlough and fails to make required premium payments in advance.

(d) In addition to the above, coverage for dependents will end if:

1. The dependent no longer meets the SHBP definition of an eligible dependent found at N.J.A.C. 17:9–3.1;

2. The dependent dies;

3. The dependent enters the Armed Forces; or

4. The subscriber fails to make required premium payment(s) for dependents.

As amended, R.1973 d.8, effective January 4, 1973.
See: 4 N.J.R. 282(a), 5 N.J.R. 59(b).
As amended, R.1979 d.261, effective July 3, 1979.
See: 11 N.J.R. 208(b), 11 N.J.R. 415(a).
As amended, R.1983 d.44, effective March 7, 1983.
See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).
The word "premiums" was changed to "charges" and "his" to "his or her".
Amended by R.1989 d.336, effective July 3, 1989.
See: 21 N.J.R. 886(b), 21 N.J.R. 1836(b).
Reenrollment provisions added at (c)6.
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.

Cross References

See sections 4.2 (State; full-time defined) and 4.6 (Local; full-time defined) of this chapter in reference to the limited continuation of coverage while on sabbaticals.

17:9–7.3 Continuation of coverage

(a) The coverage of an employee, and an employee's dependents, may be continued if:

1. The employee has an award pending or received an award of periodic benefits under Workers' Compensation and the employee is not otherwise covered as an employee or retiree under the State Health Benefits Program. The employee may continue coverage and the coverage of the employee's dependents, provided that the employee shall pay to the employer in advance that portion, if any, of the charges due from the employee to continue the coverage;

2. The employee is on an approved leave of absence without pay. The coverage of such employee and such employee's dependents may be continued by such employee, provided that the employee shall pay in advance the total charge required for the employee's coverage and coverage of the employee's dependents during such period of authorized leave of absence without pay; provided that no period of continued coverage, as provided above, shall exceed a total of 20 biweekly payroll periods, or nine months, during which the employee receives no pay. After the 20 biweekly payroll periods, or nine months, the employee may continue coverage through COBRA for the remaining balance of the COBRA continuation period; or

3. The employee is on an approved State or Federal Family Leave.

i. The State Family Leave Act (N.J.S.A. 34:11B–1 et seq.) entitles an employee to continue 12 weeks of SHBP coverage in any 24–month period at the expense of their employer. This includes all health care benefits, including Prescription Drug, Dental and Vision Care benefits if the employer provides them. State Family Leave includes leave from employment to provide care for the birth or adoption of a child, or the serious illness of a child, parent or spouse. It does not provide for a leave due to the personal illness of the employee.

ii. The Federal Family Leave Act (Family and Medical Leave Act of 1993, 29 U.S.C. §§ 2601 et seq.) has benefits similar to the State Family Leave Act with the exception that the Federal act also requires that leave be permitted for the employee's own serious illness of up to 12 weeks in any 12–month period.

iii. In cases where the employee on an approved Family Leave has a deduction, the employer must make arrangements with the employee to receive direct payment for the required employee contribution. If the SHBP does not receive full payment from the employer, then the employee's benefit coverage will be terminated under the termination provisions of the SHBP program.

iv. The time an employee spends on Federal or State family leave shall not count as part of the COBRA eligibility period should an employee receive approval from their employer to extend the leave.

Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.

17:9–7.4 Voluntary termination

A subscriber may elect voluntarily to terminate coverage for the subscriber or the subscriber's dependents at any time, but termination of the subscriber's own coverage shall automatically terminate the coverage of the subscriber's dependents. Such voluntary termination shall be effected by written notice thereof to the State Health Benefits Bureau by use of the New Jersey State Health Benefits Program application. Coverage may be reinstated for active employees after termination for the eligible employee and eligible dependents in accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and during any subsequent open enrollment period. Coverage may be reinstated for retirees after termination of the retiree and eligible dependents only as permitted in Subchapter 6.

As amended, R.1978 d.442, effective December 26, 1978.
See: 10 N.J.R. 456(a), 11 N.J.R. 105(b).
As amended, R.1983 d.44, effective March 7, 1983.
See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).
Reference to female employees added.
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.

SUBCHAPTER 8. EMPLOYEE PRESCRIPTION DRUG PLAN

17:9–8.1 Employee Prescription Drug Plan

(a) The Employee Prescription Drug Plan was established under the provisions of N.J.S.A. 52:14–17.29(F).

(b) Separate election shall be required for enrollment and for a change in, or a termination of, coverage in the Employee Prescription Drug Plan.

(c) The rules for eligibility and for determining the effective dates of coverage are the same as those of the State Health Benefits Program as administered by the State Health Benefits Commission in accordance with the provisions of N.J.S.A. 52:14–17.25 et seq. with the following exceptions:

1. Except under the provisions of the Federal COBRA law, prescription drug coverage is not continued in the event of death, retirement, or other termination of the group coverage;

2. There is no right of conversion of Employee Prescription Drug Plan coverage to non-group coverage;

3. Employers, other than the State of New Jersey, may offer to their employees and eligible dependents enrollment in the State Employee Prescription Drug Plan, or another free-standing prescription drug plan, or elect to have prescription drug coverage under the offering of their State Health Benefits Program medical plans.

i. If the employer elects to offer a free-standing prescription drug plan, the employee's share of the cost for this prescription drug plan may be determined by a formula different from that used to determine the employee's share of the cost of health coverage. The employee may pay a share of the cost of prescription drug coverage for the employee and for the employee's covered dependents as required by a bargaining unit agreement. The employer may establish by ordinance or resolution, rules for the employee's share of the cost for those employees not covered under a bargaining agreement.

ii. If an employer, other than the State of New Jersey, offers a free-standing prescription drug plan other than the State Employee Prescription Drug Plan, this Plan must be comparable in design, as determined by the Commission, to the State Employee Prescription Drug Plan. If an employee declines the employer's offering of a prescription drug plan, no reimbursement for prescription drugs will be provided under the State Health Benefits Program medical plan in which the member is enrolled; and

4. Prescription drug classifications that are not eligible for coverage under the employer's prescription drug plan are also not eligible for coverage under the State Health Benefits Program medical plans except as Federally or State mandated.

Repeal and New Rule, R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Section was "State Prescription Drug Program comparable to State Health Benefits Program".

17:9–8.2 Prescription drug cards

Identification cards shall be issued by the carrier upon initial enrollment or change of coverage. Identification cards may be reissued periodically. For State employees, each issue may reflect the bargaining unit in which the State employee participates. All cards will be mailed directly to the subscriber's home whenever possible. Otherwise, cards are to be distributed through the payroll and personnel officers.

Recodified from 17:1–10.2 and amended by R.1993 d.268, effective August 2, 1993.
See: 25 N.J.R. 675(b), 25 N.J.R. 3506(b).
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.

17:9–8.3 Termination; effective date

(a) The effective date of termination shall be the last day of the coverage period corresponding to the payroll period or month in which the last payroll deduction was made from the employee's salary for the coverage of dependents, if any are required, or the last charge shall have been paid by the State for employee's and/or his or her dependents' coverage or by the local employer for the employee and/or his or her dependents, as the case may be. Coverage may continue under the conditions set forth in N.J.A.C. 17:9–7.3.

(b) Eligibility shall be terminated in accordance with the provisions of N.J.A.C. 17:9–7.2.

New Rule, R.1993 d.268, effective August 2, 1993.
See: 25 N.J.R. 675(b), 25 N.J.R. 3506(b).
Amended by R.1995 d.3, effective January 3, 1995.
See: 26 N.J.R. 2202(a), 27 N.J.R. 128(a).
Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
In (a), added the second sentence; in (b), substituted N.J.A.C. reference for "as follows" in the introductory paragraph and deleted 1 through 6.

SUBCHAPTER 9. STATE EMPLOYEE GROUP DENTAL PROGRAM

17:9–9.1 State Employee Group Dental Program

(a) The State Employee Group Dental Program was established under the provisions of N.J.S.A. 52:14–17.29(F).

(b) The program is voluntary. A separate election will be required for enrollment and for a change in, or a voluntary termination of, coverage in the State Employee Group Dental Program.

(c) The rules for eligibility and for determining the effective dates of coverage are the same as those of the State Health Benefits Program as administered by the State Health Benefits Commission in accordance with the provisions of N.J.S.A. 52:14–17.25 et seq. with the following exceptions:

1. Except under the provisions of the Federal Consolidated Omnibus Budget Reconciliation Act of 1985, 29 U.S.C. §§ 1161–1168 (COBRA) law, coverage is not continued in the event of death, retirement, or other termination of the group coverage;

2. There is no right of conversion from a Plan participating in the State Employee Group Dental Program to non-group coverage;

3. Duplicate coverage is not permitted; an individual may be covered as an employee or as a dependent but not as both an employee and a dependent;

4. Coverage may be continued during an approved leave of absence without pay of not more than three months (six biweekly pay periods) provided the employee pays the entire premium in advance (employer and employee shares of the premium for employees and dependents);

5. All employees enrolled for coverage are required to participate in the plan for a minimum 12–month period while eligibility for coverage exists unless minimum enrollment requirement is waived by the State Health Benefits Commission;

6. Dependent coverage may be increased or decreased if a qualifying event occurs as defined by N.J.A.C. 17:9–2.4; and

7. If the member ceases to be eligible for coverage as defined in N.J.A.C. 17:9–7.2, coverage will terminate.

(d) Where the otherwise eligible employee elects a voluntary furlough, as authorized by N.J.S.A. 11A:6–1.1, coverage shall continue with the employer paying the costs as if the member were an active employee, provided that the employee remits in advance to the employer the amount required for the employee's contribution for coverage.

(e) Where the otherwise eligible employee elects a voluntary furlough extension, coverage may continue as if the member were an active employee provided that the employee pays the entire premium in advance (employer and employee shares for employee and dependents) unless the requirement is waived by the Merit System Board of the Department of Personnel.

Amended by R.1995 d.3, effective January 3, 1995.
See: 26 N.J.R. 2202(a), 27 N.J.R. 128(a).
Repeal and New Rule, R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Section was "State Dental Expense Program comparable to State Health Benefits Program".

17:9–9.2 Dental identification cards

Identification cards will be issued by the carrier upon the initial enrollment or change of coverage. Identification cards will be reissued periodically to assure the validity of coverage. All cards will be mailed directly to the employee's home.

Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.

17:9–9.3 Enrollment charges

Each eligible employee who enrolls for coverage shall be required to authorize the taking of deductions in order to pay for the employee's share of the cost of coverage for the employee and enrolled dependents.

Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.

17:9–9.4 Enrollment forms

At the time each employee first becomes eligible for coverage, the employee may complete an enrollment form indicating the employee's election to enroll for coverage on the employee's own behalf and on behalf of the employee's qualified dependents under one of the options to be provided in the contract. When new dependents are acquired subsequent to enrollment, the employee must complete a new enrollment application within 60 days of the event to add such dependent(s) to the coverage. In the absence of any authorization for payroll deductions, coverage cannot be extended.

Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.

17:9–9.5 Annual enrollment period

An employee who does not select coverage for the employee, or for the employee's eligible dependents when first eligible, may complete and submit an enrollment application to start such coverage during any subsequent open enrollment period.

Repeal and New Rule, R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Section was "Annual enrollment period".

17:9–9.6 Waiting period—orthodontics under the dental expense plan

Credit for qualified State service immediately preceding the employee's election to participate in the plan or during any annual enrollment period shall count towards establishing the 10 months or more of continuous service required for orthodontics. Otherwise, all other benefits will be available and such participants will become eligible for orthodontics as soon as 10 months of continuous qualified State service has been accumulated.

Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.

17:9–9.7 Covered expenses

The Plan handbook supplements the master contracts and contains the specific provisions for services to be covered and those which are excluded.

Amended by R.2003 d.437, effective November 3, 2003.
See: 35 N.J.R. 2587(a), 35 N.J.R. 5149(a).
Rewrote the section.

SUBCHAPTER 10. PROCUREMENT OF STATE HEALTH BENEFITS PROGRAM CONTRACTS

Authority

N.J.S.A. 52:14–17.27 and 17.28.

Source and Effective Date

R.2004 d.106, effective March 15, 2004.
See: 35 N.J.R. 5216(a), 36 N.J.R. 1359(b).

17:9–10.1 Purpose

This subchapter establishes the rules governing the procurement of contracts by the State Health Benefits Commission for health benefit services and related actuarial and auditing services. The Commission, created by Section 3 (N.J.S.A. 52:14–17.26) of the New Jersey Health Benefits Program Act, P.L. 1961, c.49 (N.J.S.A. 52:14–17.25 et seq.) as amended and supplemented, is responsible for negotiating and arranging for the purchase of such services.

17:9–10.2 Source for public information

The public may obtain information concerning the Commission's procurement program and pending procurements by writing to the Director, Division of Pensions and Benefits, PO Box 295, Trenton, New Jersey 08625–0295.

17:9–10.3 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Auctioning" means, in a negotiated procurement, the practice of promoting price bidding between bidders by disclosing other bidders' prices and/or holding repeated rounds of best and final offers.

"Best and final offer" means, in a procurement permitting negotiations, the bid proposal resubmitted by the bidder at the end of negotiations.

"Bidder" refers to the vendor submitting a bid proposal in response to a Request for Proposal.

"Bid proposal" refers to the bidder's offer to furnish services in response to a Request for Proposal.

"Bid list" refers to a list of vendors maintained by the Division of Pensions and Benefits who have expressed an interest in submitting bid proposals in response to future Requests for Proposals.

"Bypass" refers to a contract award to other than the lowest priced responsive bidder. A bypass occurs when the Commission determines that the bid proposal that is most advantageous to the State is not the lowest priced, responsive bid proposal.

"Commission" means the State Health Benefits Commission.

"Competitive range" refers to those responsive bid proposals determined to have a reasonable possibility of being selected for contract award following evaluation.

"Contract" is a written agreement between the Commission and the contractor setting forth obligations, including: performance of work, furnishing of labor and materials, and the basis of payment.

"Contract documentation" refers to paperwork verifying that the selected bidder has satisfied the conditions precedent to contract execution. Examples include: evidence of compliance with State Affirmative Action requirements, N.J.S.A. 10:5–31 et seq.; evidence of compliance with the MacBride principles of nondiscrimination in employment, N.J.S.A. 52:34–12.2; evidence of business registration with the Division of Revenue; required certificates of insurance; and required performance security.

"Contract execution" refers to the signing of the contract by the selected bidder and the Director following Commission approval and the selected bidder's submission of contract documentation.

"Contractor" refers to the individual, partnership, firm, corporation, company, or joint venture contracting with the Commission for the performance of the work that is the subject of the Request for Proposal.

"Day" means business day, not including Saturday, Sunday or a State legal holiday.

"Director" refers to the Director of the Division of Pensions and Benefits.

"Division" refers to the Division of Pensions and Benefits.

"Evaluation committee" refers to a formal selection committee established by the Director to evaluate bid proposals received in response to a Request for Proposal on the basis of price and other factors, as set forth in the Request for Proposal.

"Evaluation criteria" refers to factors set forth within the Request for Proposal, usually weighted, specifying the basis for the technical evaluation of bid proposals received.

"Filed" means received by the Director.

"Negotiation" refers to discussions conducted with responsive bidders whose bid proposals are determined to be within the competitive range.

"Notice of Intent to Award" refers to the Director's correspondence to all bidders advising of the Commission's contract award decision.

"Performance security" means a guarantee, in the form of a deposit or a bond, submitted by the selected bidder subsequent to the Notice of Intent to Award and prior to contract execution, that the selected bidder will complete the contract and that the Commission will be protected from loss in the event the selected bidder fails to complete the contract.

"Protest" refers to a timely challenge of a Request for Proposal requirement or to the Commission's contract award decision.

"Request for Proposal" or "RFP" refers to all documents, whether attached or incorporated by reference, used for soliciting bid proposals for the services specified therein.

"Responsible bidder" refers to a bidder who has demonstrated integrity and the capability to successfully provide the services being procured.

"Responsive bidder" refers to a bidder whose bid proposal conforms to all material requirements of the RFP.

"State" refers to the State of New Jersey.

"Technical leveling" means, in a negotiated procurement, helping a bidder bring its bid proposal up to the level of other bid proposals through successive rounds of negotiations by pointing out the weaknesses that remain in the bid proposal due to the bidder's lack of diligence, competence or inventiveness.

"Technical transfusion" means, in a negotiated procurement, the disclosure of the contents of one bidder's bid proposal to another bidder to help the other bidder improve its bid proposal.

17:9–10.4 Procurement methodology

(a) All purchases shall be through formal, advertised sealed bidding, except as provided in this subchapter.

(b) The Director shall prepare the RFP for formal, advertised, sealed bidding at the request of the Commission.

(c) The Director shall structure the RFP for formal, advertised, sealed bidding to provide for a single contract award to a single bidder, unless contract awards to two or more bidders are permitted as hereinafter provided in this subchapter.

17:9–10.21 Mutual cancellation of contract

Upon receipt of a written request from a contractor, the Commission may, under extraordinary circumstances, agree to a mutual cancellation of the contract. The Commission may require the contractor pay the difference in price, if any, associated with securing the services from another source and any administrative expenses associated therewith.

17:9–10.22 Waiver of time periods

The Director or the Commission may, in instances where public exigency exists or where there is potential for substantial cost benefit or other advantage, modify or amend the time periods set forth in this subchapter. In such an instance, the Director or the Commission shall give adequate notice to the parties involved.

17:9–10.23 Authority to contract

Nothing in the rules set forth in this subchapter shall preclude the Commission from requesting the Division of Purchase and Property to contract on the Commission's behalf for medical benefit services and related actuarial and auditing services. In such instance, the procurement rules, policies and procedures of the Division of Purchase and Property, N.J.A.C. 17:12, shall govern.

SUBCHAPTER 11. PART–TIME EMPLOYEES GROUP

Authority

N.J.S.A. 52:14–17.27.

Source and Effective Date

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

Subchapter Historical Note

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

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

(a) The State Health Benefits Program Part–Time Employees Group was established under the provisions of P.L. 2003, c.172 (N.J.S.A. 52:14–17.33a).

(b) Enrollment for coverage is voluntary. A separate election will be required for enrollment, change in or a voluntary termination of coverage in the Part-time Employees Group. If an employee does not elect coverage within 60 days of eligibility for participation in the Part-time Employees Group, the employee may only enroll during an open-enrollment period.

(c) The laws and regulations governing the State Health Benefits Program, except as modified in this subchapter, are construed to apply to part-time employees or faculty members and their dependents to the extent possible.

(d) Except under the provisions of the Federal Consolidated Omnibus Budget Reconciliation Act of 1985, 29 U.S.C. §§ 1161–1168 (COBRA) law, coverage is not continued in the event of death, or other termination of the group coverage. There is no right of conversion from the Part–Time Employees Group to nongroup coverage.

(e) Duplicate coverage is not permitted; an individual may be covered only once. An individual eligible as both a subscriber and as the dependent of someone else can be enrolled as an employee or as a dependent but not as both an employee and a dependent.

(f) Coverage may be continued during an approved leave of absence without pay of not more than nine months provided the employee pays the monthly premium.

(g) Eligible dependents may be added during the open enrollment or if a qualifying event occurs as defined by N.J.A.C. 17:9–2.4.

(h) Where the otherwise eligible employee elects a volunteer furlough or a voluntary furlough extension, as authorized by N.J.S.A. 11A:6–1.1, coverage shall continue with the employee paying the costs as if the member were an active employee, provided that the employee remits, in advance, the monthly amount required for the employee's coverage.

17:9–11.2 Eligible part-time employees

Part-time employees of the State, including employees of the State colleges and universities, New Jersey Building Authority, New Jersey State Library, Palisades Interstate Parkway Commission, and the Commerce and Economic Growth Commission, as well as part-time faculty at county colleges participating in the SHBP, are eligible to enroll if they are members of the State-administered retirement system.

17:9–11.3 Coverage available

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

(b) Pursuant to P.L. 2003, c.172 (N.J.S.A. 52:14–17.33a), members of the Part-time Employees Group shall be eligible for coverage in NJ PLUS. Members shall also be eligible for coverage under the State Employee Prescription Drug Plan. There shall be no prescription drug coverage under NJ PLUS.

(c) Eligible employees may waive enrollment in the State Employee Prescription Drug Plan, but in no case shall they be allowed to enroll in the State Employee Prescription Drug Plan without also being enrolled in NJ PLUS.

(d) There is no eligibility for dental or vision or any other benefit created by P.L. 2003, c.172.

17:9–11.4 Payment of coverage

The employee will be billed directly for the cost of premiums plus administrative fees.

17:9–11.5 Cost of coverage

The State Health Benefits Commission may adopt separate rates for the Part-time Employees Group reflecting the actual cost of the benefit plus administrative costs.

17:9–11.6 Effective date of coverage

(a) Coverage for all members of the Part-time Employees Group shall be on a monthly basis.

(b) The coverage for members eligible to enroll in the Part-time Employees Group shall be effective on the first of the month following the completion of two months of continuous service after enrollment in a State-administered retirement system, or two months after the effective date of P.L. 2003, c.172 (January 1, 2004). This is the normal waiting period prescribed for new enrollees pursuant to N.J.S.A. 52:14–26. Billing for coverage shall begin approximately one month prior to the effective date.

(c) An employee hired under a 10–month contract whose enrollment in a State-administered retirement system becomes effective on September 1 may establish coverage in the Part-time Employees Group as of that date.

17:9–11.7 Effect of full-time employment on participation in the Part-time Employees Group

A member of the Part-time Employees Group who changes from part-time to full-time status cannot be enrolled for employer-paid coverage until the employee has established eligibility for coverage by serving the normal waiting period prescribed for new enrollees. In no event will the waiting period for full-time coverage include any part-time service rendered by the employee.

17:9–11.8 Termination of coverage due to nonpayment of premiums

(a) Cessation of coverage in the Part-time Employees Group shall be deemed to occur on the last day of eligibility for the coverage period for which charges have been paid.

(b) If a member of the Part-time Employees Group does not remit payment by the end of the month in which payment is due and owing, the SHBP shall notify the member of the overdue amount plus the current amount due on the next billing statement; such notice shall also advise the member that the right to continue coverage will be terminated if payment in full is not remitted within 30 days. If no payment is made by the due date, the SHBP shall terminate the coverage effective on the last day of the month for which premiums were paid.

(c) Termination for nonpayment of premiums is not a COBRA event. An active employee terminated for nonpayment of premiums would not be able to re-enroll in the Part-time Employees Group until the next regular open enrollment.

17:9–11.9 Termination of coverage due to termination of employment with an eligible employer

The eligibility for coverage for members of the Part-time Employees Group ends at the end of the month in which termination from an eligible employer occurs. The employer must notify the Division of Pensions and Benefits of the termination and issue the employee a COBRA notice.

17:9–11.10 Coverage in retirement

(a) Participation in the Part-time Employees Group pursuant to this section shall not qualify the employee or faculty member for employer-paid or State-paid health care benefits in retirement. Upon retirement, such employees or faculty members who were enrolled in NJ PLUS immediately prior to retirement shall be eligible to continue NJ PLUS coverage as a retiree at their own expense. Prescription drug benefits under NJ PLUS shall be provided through the Retiree Prescription Drug Card Plan (N.J.A.C. 17:9–6.10).

(b) Whenever possible, the cost of retiree coverage will be deducted directly from the retirement allowance or pension checks. Where the available retirement allowance or pension check is less than the charge for coverage, no amount will be deducted to pay for the cost of the coverage; instead, the retiree will be permitted to continue coverage if the retiree pays for the full cost of coverage in advance on a monthly basis.

(c) An eligible surviving spouse will be offered the opportunity to continue participation in NJ PLUS subsequent to the death of the retiree. Coverage will be limited to only those dependents covered at the time of the retiree's death. The surviving spouse must pay the full costs.