

**16:83-2.4 Application for Banner Permit**

(a) The application for a Banner Permit, signed by the applicant, shall contain the following:

1. The applicant's name, title, address, and telephone number and the name of the organization, which the applicant represents;
2. The name(s) and contact information of the banner-hanging organization that will have supervision of and responsibility for placement, installation, and maintenance and removal of the banner during the term of the Banner Permit;
3. A statement that the proposed advertisement is for a non-commercial community special event, is open to the public, and includes specific calendar dates on which the activity will take place;
4. The verbatim text and graphics to be used in the banner; and
5. If requested by NJ TRANSIT, the Banner Permit holder shall supply a list of credible professional references who can attest to the qualifications of the banner-hanging company.

**16:83-2.5 Validity of Banner Permit**

(c) A Bridge Banner Permit is valid for up to, but not more than, 14 days. The bridge banner shall be removed no later than noon following the final date appearing on the Banner Permit.

**16:83-2.6 Disposition of application; appeal of denial**

(a) If NJ TRANSIT denies an application for a Certificate of Registration or Banner Permit, the denial shall be in writing and state the reasons for the denial.

(b) The applicant may appeal this denial in writing by contacting the Assistant Executive Director (AED), Communications and Customer Service, New Jersey Transit Corporation, One Penn Plaza East, Newark, NJ 07105-2246, and shall include a statement describing the nature of the appeal and what factual issues, if any, shall be in dispute. If any factual dispute is alleged, the AED, Communications and Customer Service or his or her designee shall conduct a review on the papers and render a decision, within 15 days after receipt of such appeal. The decision shall be made in writing and shall set forth the basis for the decision. Where an applicant wishes to contest this decision, the applicant may, within 30 days, request a contested case hearing and the matter shall be forwarded to the Office of Administrative Law for fact finding before an Administrative Law Judge (ALJ), pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and 52:14F-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1. The ALJ shall issue an initial decision, which shall be returned to the NJ TRANSIT Board of Directors for a final agency decision.

**16:83-[2.5]2.7 Limitation of Certificate or Banner Permit**

NJ TRANSIT may cancel, temporarily defer, or modify the Certificate or Banner Permit for emergent public health, welfare, or safety reasons, including extraordinary weather, power failures, accidents, terrorism, disasters, strikes, riot, fire, civil disorder, service disruptions, special NJ TRANSIT-sponsored customer service events or other events, which create an unsafe condition in the relevant expressive area or which substantially interfere with the transportation related activities of the facility. NJ TRANSIT may revoke or suspend any Certificate or Banner Permit where it has concluded that the Certificate or Banner Permit holder has violated the requirements of the Certificate or Banner Permit, these rules, or both.

Recodify existing 16:83-2.6 through 2.9 as **2.8 through 2.11** (No change in text.)

**16:83-[2.10]2.12 Banner installation, maintenance and removal**

(a)-(b) (No change.)  
 (c) [NJ TRANSIT may also, at its sole discretion, establish and charge appropriate fees to recover estimated direct and indirect costs of labor, equipment, and administrative expenses associated with the issuance of Bridge Banner Permits.] If access to the track is requested for any reason, and the request is granted, an NJ TRANSIT railroad protective flagman is required and the Banner Permit holder shall be liable for all associated labor and administrative costs.

(d) (No change.)

Recodify existing 16:83-2.11 and 2.12 as **2.13 and 2.14** (No change in text.)

**TREASURY-GENERAL****(a)****DIVISION OF PENSIONS AND BENEFITS****State Health Benefits Program****Proposed Readoption with Amendments: N.J.A.C. 17:9****Proposed Repeal and New Rule: N.J.A.C. 17:9-3.5**

Authorized By: State Health Benefits Commission, Kierney Corliss, Acting Secretary.

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

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2016-069.

Submit comments by July 15, 2016, to:

Susanne Culliton  
 Assistant Director  
 Division of Pensions and Benefits  
 PO Box 295  
 Trenton, NJ 08625-0295  
[DPB.Regulations@treas.nj.gov](mailto:DPB.Regulations@treas.nj.gov)

The agency proposal follows:

**Summary**

The State Health Benefits Commission (Commission) is responsible for reviewing N.J.A.C. 17:9, the administrative rules governing the State Health Benefits Program (SHBP). When these rules are due to expire, or when the Commission becomes aware of a change in the laws or a court decision that impacts the SHBP, the administrative rules are examined to see if any changes are mandated. When revision is necessary, steps are taken to propose amendments or new rules that uphold the new statute or court decision. Additionally, the rules are periodically reviewed to ascertain if they are necessary, cost efficient, and reflect current practices. As the Commission has provided a 60-day comment period on this notice of proposal, this notice is excepted from the rulemaking calendar requirement pursuant to N.J.A.C. 1:30-3.3(a)5.

Accordingly, the Commission proposes to readopt the current rules within N.J.A.C. 17:9, pursuant to N.J.S.A. 52:14B-5.1, with the following amendments, repeal, and new rule. The rules at N.J.A.C. 17:9 are scheduled to expire on April 6, 2016, pursuant to N.J.S.A. 52:14B-5.1, however, as the Commission has filed this notice of re Adoption with the Office of Administrative Law prior to that date, the expiration date of the chapter is extended 180 days to October 3, 2016, pursuant to N.J.S.A. 52:14B-5.1.c(2). This chapter governs all aspects of the administration of the SHBP, including health coverage, dependents, employees, charges, retirement, termination, prescription drug programs, and dental expense programs.

The proposed amendments are as follows:

**Subchapter 1. Administration**

At N.J.A.C. 17:9-1.2(a), the reference to the open public meetings act is proposed for correction of the citation and the name of the act, as the name of the Act was changed pursuant to P.L. 2006, c. 70, to honor Senator Baer, the Act's sponsor.

N.J.A.C. 17:9-1.3(a) is proposed to be amended to limit the window for member requests for Commission consideration to a period of one year within the plan's final adverse benefit determination, once all internal appeals within the plan have been exhausted. This amendment will make this process more efficient. Subsection (a) will also be proposed for amendment to include the external review process, which is now required under the Federal Patient Protection and Affordable Care Act (PPACA).

At N.J.A.C. 17:9-1.4, the word "Commission" is to be replaced by "Division" in the second and third sentences, since the Division actually accepts completed resolutions submitted by employers on behalf of the Commission. The first change occurs in the second sentence, in the phrase, "the first day of the month following a period beginning 75 days after the receipt by the Commission," where "Commission" is to be replaced by "Division." The second change occurs in the last sentence, in the phrase, "the first day of the month following a period beginning 90 days after the receipt by the Commission," where "Commission" is to be replaced by "Division" again. In addition, new subsection (d) is proposed and specifies that employers must satisfy all outstanding balances from previous participation before re-entry will be approved. The purpose of this subsection is to make employers responsible for previous financial obligations before allowing SHBP re-entry.

At N.J.A.C. 17:9-1.5, the word "Commission" is again proposed to be replaced with "Division." As explained above, the Division accepts completed resolutions submitted by employers on behalf of the Commission.

N.J.A.C. 17:9-1.6(a) is proposed for amendment, so that it specifies an effective date of termination of coverage in cases where an employer is in default for non-payment of coverage charges.

The rules governing local employer incentives for non-enrollment at N.J.A.C. 17:9-1.7 are proposed for amendment to comply with changes required under P.L. 2010, c. 2. For all waivers filed on or after May 21, 2010, the effective date of P.L. 2010, c. 2, the incentive shall not exceed \$5,000 or 25 percent of the amount saved by the employer, whichever is less. For waivers filed before that date, the incentive may be up to 50 percent of the amount saved by the employer. In addition, new subsection (c) is proposed, to allow public employees who have filed waivers of coverage and are otherwise eligible for SHBP coverage to enroll immediately into the SHBP if other coverage or the waiver ends for any reason. Further, new subsection (d) is proposed, to indicate the procedures and forms for notifying the SHBP in order to waive coverage or resume coverage, and new subsection (e) is added to indicate that no monetary incentive is allowed when a member waives coverage because of other SHBP or SEHBP coverage. Finally, new subsection (f) is proposed to indicate that adoption of the waiver incentive does not require an employer resolution (thereby replacing existing subsection (c), which is proposed for deletion), while new subsection (g) is proposed to specify that active employees who have waived coverage will be permitted to continue coverage in retirement.

At N.J.A.C. 17:9-1.8, a number of definitions are proposed to be added, amended, or deleted in accordance with P.L. 2007, c. 103 and N.J.S.A. 52:14-17.26. The definitions for "carrier," "employee," "Education Employer," "State managed care plan," "Medicare," "SEHBP," and "traditional plan" are to be added. "Civil union partner," "dependent," "eligible employer," and "successor plan" are proposed for amendment, based on changes brought about under P.L. 2007, c. 103. One important change to N.J.A.C. 17:9-1.8, based upon the Federal PPACA, is that children are now eligible as dependents through December 31 of the year in which they attain the age of 26, instead of age 23, as long as all other eligibility requirements are met. Further, the definition for "dependent" has also been modified to reflect that children need not live with the subscriber to be a dependent for SHBP coverage, and "Eligible Employer" will be modified so that local school employers are included, pursuant to N.J.A.C. 17:1-15.2, until the rules for the School Employees' Health Benefits Program (SEHBP) are adopted. "Successor plan" is to be modified to include applicable statutes and to remove the phrase "with a payment of 80 percent of reasonable and customary," as this no longer applies. In addition, the definition of "spouse" is proposed for amendment by eliminating the phrase "of the opposite sex," as same sex marriages are now legal at both the Federal and State level.

"Chapter 375 Dependent" is proposed for amendment through the addition of the N.J.A.C. 17:9-13 citation, where notable differences regarding SHBP coverage for this group of dependents are provided, including the cost that subscribers must assume in order to continue SHBP coverage for this category of dependents. Also, the citation provided in the COBRA definition is to be revised, so that it is correct. Furthermore, the definition for "civil union partner" is to be amended

through the deletion of, "outside the State of New Jersey" from the phrase, "a domestic partnership formed outside the State of New Jersey." This verbiage applied at a time when domestic partnerships were not legal in New Jersey, but is no longer applicable. "Domestic partner" is proposed for amendment to state that Certificates of Domestic Partnership issued in the State of New Jersey must be dated prior to February 19, 2007, in accordance with P.L. 2006, c. 103. Finally, "NJ PLUS," a previous point of service plan, is proposed for deletion, and whenever applicable, "subscriber" is to be used to refer to the person in whose name the coverage is listed, while "member" is to be used for any person who is a subscriber or a dependent, as defined in N.J.A.C. 17:9-1.8.

## SUBCHAPTER 2. COVERAGE

Proposed new N.J.A.C. 17:9-2.2(b) and (c) are added to indicate that specific rules for enrolling Chapter 375 dependents are found at N.J.A.C. 17:9-13.2, while specific rules for enrolling coverage children with disabilities are provided at N.J.A.C. 17:9-3.4.

N.J.A.C. 17:9-2.4 is proposed to be amended to include the prohibition of multiple coverage in paragraph (a)1, in accordance with P.L. 2010, c. 2, and to specify that enrollment may be in the SHBP or SEHBP, as applicable. Furthermore, paragraph (a)1 is proposed for amendment to remove references to domestic partnerships, as this no longer applies, in accordance with P.L. 2006, c. 103; additionally, coverage changes are only accepted after the date of marriage or civil union, so paragraph (a)1 is proposed for amendment accordingly.

Paragraph (a)5 is proposed for amendment to state that when children become ineligible for coverage through December 31 of the year in which they reach the age 26, as provided under the Federal Patient Protection and Affordable Care Act (PPACA), a subscriber's coverage level will change. In addition, new paragraph (a)6 is proposed to be added, specifying that when the last dependent child becomes ineligible for coverage by electing other coverage through employment, marriage, or civil union partnerships before the age of 26, the subscriber may also change coverage. Because of this addition, paragraphs (a)6 and 7 are proposed for recodification as paragraph (a)7 and 8 and existing paragraph (a)8 is proposed for deletion as recodified paragraph (a)7 already covers the area of reinstatement of depended coverage. Also, the word "dependent" is proposed for deletion from paragraph (a)5 from the phrase "when last dependent child reaches . . ." it is proposed to be replaced with the word, "covered." The word "dependent" is proposed for deletion twice from the last sentence in paragraph (a)5, so that the paragraph will state "[a]ny employee who shall have enrolled one or more children as dependents may enroll for any coverage at the time the last such child reaches age 26." The word "dependent" is also proposed for deletion from the phrase "[b]irth, adoption, or guardianship of dependent children" in recodified paragraph (a)8. These amendments are needed because children no longer need to be financially dependent upon their parents in order to qualify for dependent coverage under the SHBP, in accordance with the Federal PPACA. At existing paragraph (a)9, the existing COBRA provisions for Chapter 375 dependents are proposed to be included as subparagraphs (a)9i and ii, notably that coverage children who become ineligible for Chapter 375 medical coverage are not eligible for the continuation of medical coverage under COBRA; however, Chapter 375 dependents may continue vision and dental coverage under COBRA, since Chapter 375 does not provide vision or dental coverage for coverage dependents.

N.J.A.C. 17:9-2.8(a) is proposed for amendment by the addition of "or SEHBP" in the first sentence, since continuation of coverage will occur for transfers between a participating SHBP employer and a participating SEHBP employer, as well as between two participating SHBP employers. The phrase, "of the following year" is also being added in the second sentence, to clarify that for 10-month employees hired in September, SHBP coverage includes July and August of the following year.

N.J.A.C. 17:9-2.11 is proposed for amendment so that plan types that are currently in place are reflected in the rule.

## Subchapter 3. Dependents

At N.J.A.C. 17:9-3.1, the definition of "children" is proposed for amendment, so that it specifies that stepchildren who "live with the

subscriber” are included. At the same time, the definition, “living with” is proposed for deletion, as children are no longer required to live with a subscriber to be covered as a dependent under the subscriber’s SHBP coverage, with the exception of stepchildren, as now specified in the definition of “children.” The definition of “dependents” is proposed for amendment to change the maximum age of dependent children from 23 to 26, delete “unmarried,” and delete the phrase, “who live with the employee in a regular parent-child relationship,” as the requirements for coverage for dependent children have changed under the Federal PPACA. The PPACA requires a change in the maximum age for dependent children, but it also allows children who are married and/or no longer live with the subscriber to continue to be covered as dependents.

At N.J.A.C. 17:9-3.3, “sworn affidavits” is proposed for deletion from the list of documentation accepted for establishing dependency, as this is not current practice. The final sentence of subsection (a) is proposed for deletion, as the financial support and maintenance that is referenced is no longer required for dependent SHBP coverage for children. In addition, a reference to Division website information is proposed, to provide subscribers with immediate access to current acceptable documentation for establishing dependency.

As noted above, the age at which eligibility for continuation of coverage must be determined for children with disabilities is now 26 (see PPACA above), therefore, N.J.A.C. 17:9-3.4 is proposed for amendment accordingly. Additionally, new subsection (c) is proposed, to specify that SHBP or SEHBP coverage for an average child with disabilities who is determined to be eligible must be continuous. If a member waives coverage or removes an eligible child from coverage for any reason, the child may not be added again at a later date. This includes cases in which an employee waives active coverage and resumes coverage as a retiree.

Existing N.J.A.C. 17:9-3.5 is proposed for repeal and replacement as multiple coverage is not permitted under P.L. 2010, c. 2, and refunds and duplication of coverage are no longer permitted, so references to these are not proposed for inclusion in the new rule. Proposed new paragraphs (a)1, 2, and 3 provide the specific instances of multiple coverage that are prohibited. Proposed new subsection (b) states that waivers of coverage are allowed, pursuant to N.J.S.A. 52:14-17.31(a) and N.J.A.C. 17:9-1.7. Finally, proposed new subsection (c) states that health coverage for dependents with disabilities who are 26 or older will be denied if a member has waived coverage and the waiver is in effect at the time the dependent attains the age of 26.

#### Subchapter 4. Employees

N.J.A.C. 17:9-4.1(a) is proposed for amendment to reflect the 35 hours per week requirement for full-time employee status for State employees, under P.L. 2010, c. 2. Further, paragraph (a)3 is proposed for replacement by deleting the University of Medicine and Dentistry of New Jersey and replacing it with University Hospital, as all schools, institutes, and centers of the University of Medicine and Dentistry of New Jersey (UMDNJ) were transferred to other entities, and University Hospital became the principal teaching hospital of New Jersey Medical School and New Jersey Dental School, under the “New Jersey Medical and Health Sciences Education Restructuring Act,” P.L. 2012, c. 45. References to UMDNJ were to be eliminated when it ceased to exist.

N.J.A.C. 17:9-4.2(a)4, 5, and 6 are proposed for deletion as they no longer apply under the present definition of full-time.

N.J.A.C. 17:9-4.6 is proposed for amendment, so that the number of hours worked for “full-time” status cannot be less than 25 hours, rather than 20 hours; however, each participating local employer will continue to determine the number of hours required for “full-time” status, by way of resolution, as long as the minimum requirement of 25 hours is met.

#### Subchapter 5. Charges

N.J.A.C. 17:9-5.2(a) is proposed for amendment to prohibit the granting of a premium delay to employers requesting re-entry while having an existing outstanding balance from previous participation. The purpose of the added condition is to discourage employers from terminating participation and subsequently re-entering in order to avoid payment of outstanding employer obligations.

N.J.A.C. 17:9-5.4(a)4 is proposed for amendment to state that a local employer will satisfy the requirements of P.L. 1974, c. 88, by adopting a

resolution designed to require the local employer to pay all “or some” of the health benefits for retirees, rather than the full cost, if other conditions are met. Since the provisions of current P.L. 2011, c. 78, requiring local retirees who attain 25 years of service credit on or after June 30, 2011, to pay a percentage of the premium based on their retirement allowance, will remain in effect until collective negotiations agreements bring about a change to this requirement, paragraph (a)4 is also proposed for amendment accordingly. Because the provisions of P.L. 2011, c. 78, are not new, this provides clarification regarding the continuation of the Chapter 78 provisions that are specified above.

N.J.A.C. 17:9-5.5(a)4 is proposed for amendment to specify that in cases where a Medicare reimbursement cannot be added to the retirement allowance, reimbursements will be mailed to the retiree on an annual basis, for the previous 12-month period, but for ABP members, the reimbursement will be mailed on a monthly basis.

At N.J.A.C. 17:9-5.6, the reference to refunds under N.J.A.C. 17:9-3.5 is no longer permitted, so that citation is proposed for deletion.

Pursuant to P.L. 2011, c. 78, N.J.A.C. 17:9-5.9 is proposed for amendment to reflect the contributions that employees must now make for their health coverage, which are based on each employee’s salary and level of coverage selected. The provisions of P.L. 2011, c. 78, as indicated above, are not new; however, since they will remain in effect until collective negotiations agreements are reached that bring about changes to this requirement, this provides clarification regarding the continuation of the Chapter 78 provisions specified above.

#### Subchapter 6. Retirement

Subsection (c) of N.J.A.C. 17:9-6.1(c) is proposed for amendment to specify that disability retirements are not available to PERS and TPAF employees enrolled on or after May 21, 2010, and new subsection (h) is proposed to state that a “retired employee” shall also include PERS and TPAF employees enrolled on or after May 21, 2010, who are approved to receive a long-term disability benefit, as long as all other eligibility requirements are met. Recodified subsection (l) is proposed for amendment to include cross-references to N.J.S.A. 18A:66-39.1 and 43:15A-42.1, which specify how employer liability for payments to PERS and TPAF employees eligible for long-term disability benefits shall be paid.

N.J.A.C. 17:9-6.3(e), regarding Medicare Part D is proposed for amendment to state that enrollment in a “non-SHBP” Medicare Part D plan will cause SHBP retiree prescription drug benefits to be terminated for the retired employee and all dependents, but will not affect the continuation of SHBP medical benefits. Similarly, subsection (f) is proposed for amendment to state that if the retired employee and where applicable, the retired employee’s dependent(s), terminate the “non-SHBP” Medicare Part D plan coverage, the retired employee and dependent(s) may enroll or reenroll in the SHBP retiree prescription drug program prospectively. These amendments are necessary because the SHBP now offers a Medicare Part D prescription plan to Medicare-eligible retirees covered by the SHBP and their spouses/partners.

N.J.A.C. 17:9-6.8(a) is proposed for amendment to add “and were continuously employed,” to be consistent with the manner in which this subsection is applied, that is, the condition of continuous employment must be met. At Paragraph (b)1, Aetna Freedom 10 is proposed to be included with NJDIRECT 10, as paragraph (b)1 applies to both plans. In subsections (c), (d), and (e), Aetna Freedom 10 is to be added and “NJ DIRECT 15” is to be replaced with “other plans” or “other participating plans,” as applicable, as a number of participating HMOs with comparable service and cost are now offered. In addition, a number of amendments are required to the premium-sharing requirements for retired employees who accrue 25 or more years of service, specifically in recodified subsection (f) and proposed new subsections (g) and (h); those premium sharing requirements are now based on collective bargaining agreements and the specific date on which 25 years of service credit is attained, as provided under P.L. 2011, c. 78. Since P.L. 2011, c. 78, is not a new law, it is necessary to clarify here that its provisions are to remain in effect until collective negotiations agreements are reached that bring about changes to this requirement. Finally, new subsection (k) is proposed, regarding post-retirement health benefits coverage for those with less than 25 years of service upon retirement.

N.J.A.C. 17:9-6.9(b) is proposed for amendment to indicate that the State will pay 80 percent of the “least expensive premium” for the plan offered. The phrase “and the lower premium or periodic charges” in the last sentence is also proposed for deletion, as it no longer makes sense. New subsection (g) is proposed to specify that qualified retirees will be required to contribute a minimum of 1.5 percent of their retirement allowance toward their health benefits, in accordance with current statutes, specifically P.L. 2010, c. 2. In addition, proposed new subsection (h) stipulates that employers may not reimburse qualified retirees for any amount of their health plan contribution, or the qualified retirees will lose their eligibility for coverage under P.L. 1997, c. 330.

At N.J.A.C. 17:9-6.10(a), the definition of “other brands” is proposed to be relocated, so it is alphabetized correctly and “prescription drug plan” is proposed for amendment, so that it correctly includes other SHBP health plans offered to subscribers, as current procedures allow. Additionally, “preferred brands” is proposed for amendment to specify that determinations of preferred brands by the provider shall be subject to review and modification by the State Health Benefits Program Plan Design Committee, not the Commission, as the State Health Benefits Program Plan Design Committee now oversees such determinations.

N.J.A.C. 17:9-6.10 is proposed for amendment further, through the removal of references to several determinations that are no longer made by the Commission. At N.J.A.C. 17:9-6.10(b), the final sentence is proposed for deletion, as it does not apply for every plan. N.J.A.C. 17:9-6.10(d) is proposed for amendment through the deletion of the initial copayment amounts for 2000 and 2001, which is archival information, and the addition of a statement indicating that current copayment amounts and maximum out-of-pocket expenses are to be provided on the Division’s website. Existing N.J.A.C. 17:9-6.10(f), (g), (h), (k), and (l) are proposed for deletion, as the State Health Benefits Program Plan Design Committee now makes decisions about out-of-pocket expenses and co-payments, and the information is in part historical. Recodified subsection (f) is proposed for amendment to state that notices of increases are published in the New Jersey Register, but retirees affected by the increase are not sent notices, so this phrase is to be removed; instead increases are posted to the Division’s website. Finally, due to the recent repeal of N.J.A.C. 11:4-37.3(c), this statutory citation is replaced with N.J.A.C. 11:22-5, as the requirements at this subchapter relating to health benefit providers that administer prescription drug benefits shall apply to such plans.

#### **Subchapter 7. Termination**

At N.J.A.C. 17:9-7.1(c), “surviving dependents” is proposed to be replaced with “named beneficiary(ies),” as a named beneficiary would receive a retirement or death benefit, not the surviving dependent of a health plan.

N.J.A.C. 17:9-7.2(d)5 is proposed for amendment to state that SHBP coverage ends for a covered child who becomes eligible for SHBP or SEHBP coverage due to employment, “unless the child waives his or her own SHBP or SEHBP coverage to continue SHBP coverage as a subscriber’s child.” This change is needed because eligible children of subscribers now have this option available to them. Furthermore, the word “dependent” is to be replaced with “covered,” as children no longer have to be financially dependent to be covered under a subscriber’s plan, under the Federal PPACA.

#### **Subchapter 8. Employee Prescription Drug Plan**

N.J.A.C. 17:9-8.1(c)1 is proposed for amendment by removing the word “retirement,” as in many cases, retirement does not bring a discontinuation of prescription drug coverage. At subparagraph (c)2i, the phrase “free-standing prescription drug plan” is proposed for amendment to state “the State Employee Prescription Drug Plan,” as this subparagraph no longer applies to private plans, as it once did.

N.J.A.C. 17:9-8.2 is proposed for amendment by removing the reference to prescription drug cards being distributed through payroll and personnel officers. Under current practices, all prescription drug cards are mailed to the subscriber’s home.

#### **Subchapter 9. Employee Dental Plans**

At N.J.A.C. 17:9-9.1(a), the phrase “traditional indemnity-type plan” is proposed for replacement with “PPO,” to use current language that

more accurately describes the Dental Expense Plan operationally. In addition, paragraph (c)1 is proposed for deletion, as this is already stated for the health plans at N.J.A.C. 17:9-3.5 and is, therefore, not needed. Recodified paragraph (c)4 is proposed for amendment by removing the phrase, “provided that the employer’s portion of the total premium cost for the Plans shall not be 50 percent,” from the first sentence, as this is no longer accurate.

#### **Subchapter 10. Procurement of State Health Benefits Program Contracts**

At N.J.A.C. 17:9-10.3, a number of definitions are proposed to be added, amended, or removed, so that this section conforms more closely to the Department of the Treasury’s current definitions for the procurement of contracts, as set forth in N.J.A.C. 17:12-1.3. In particular, the following terms that are defined in N.J.A.C. 17:12-1.3 are proposed to be added to the list of definitions provided in N.J.A.C. 17:9-10.3, as these terms are also used in N.J.A.C. 17:9-10: “bid security,” “business registration,” “hearing officer,” “negotiation component,” “responsive proposal,” “sealed bidding,” and “signed.” A number of definitions are proposed for amendment, so that they correspond more closely to current definitions set forth in N.J.A.C. 17:12-1.3: “best and final offer,” “bypass,” “competitive range,” “contract,” “contractor,” “day or business day,” “Director,” “filed,” “performance security,” “protest,” “Request for Proposal,” and “responsible bidder.”

“Best and Final Offer” is proposed for amendment through the addition of its acronym, BAFO, and to specify that it is the price submitted by a bidder when invited to do so by the Division after proposal opening, with or without prior discussion or negotiation. “Bypass” is proposed for amendment, so that it correctly states that it is a contract award made to a proposal other than “the lowest priced responsive proposal from a responsible bidder,” not the lowest priced responsive bidder.

“Competitive range” is proposed for amendment, so that the definition states it is the group of responsive proposals that are among the most highly rated proposals, as “bid proposals determined to have a reasonable possibility of being selected for contract award” is somewhat ambiguous. “Contract” is proposed for amendment to reflect the agency’s fiscal responsibilities and to include specific procedural information for publicly advertised contracts. The definition for “contractor” is proposed for amendment, so that it is more concise; the definition now refers to “a business entity” awarded a contract, so that no type of eligible business entity is excluded.

Further, “day” or “business day” is proposed for amendment, so that State-mandated furlough days are also excluded as business days. “Director” is proposed for amendment to include the Director’s designee, who can act on behalf of the Director. Similarly, “filed” is proposed for amendment through the addition of “Director’s Division representative,” as the representative can also perform the task of receiving documents filed with the Division.

Finally, the definition of “performance security” is proposed for amendment to make it more concise and to allow all acceptable guarantees to be submitted to the Division on behalf of the Commission, and to protect the “State” from loss if the contractor selected from among the bidders fails to complete the agreed upon contract, not just the Division. In addition, the definition of “protest” is proposed for amendment, so that it specifies the types of challenges that can be filed. “Request for Proposal” is proposed for amendment to use the verbiage, “a publicly advertised procurement process that solicits proposals or offers to provide to the goods and/or services specified therein.” The revised definition includes the requirement of a “publicly advertised” procurement process that may offer “goods” as well as services. “Responsible bidder” is proposed for amendment to require a bidding entity to be deemed reliable, in addition to having integrity, and to perform all contract requirements, which is more specific than the phrase, “provide the services being procured.” The above changes will help to standardize the procurement process within the Treasury Department. In addition, the definition for “bidder” is proposed to be relocated, so it is alphabetized correctly, and “negotiation” is proposed for deletion, as it is being replaced with “negotiation component.” Finally, the definition of “contract documentation” is proposed for amendment to state that examples of contract documentation will include, “but are not limited to. . .” (the document listing provided). This amendment will allow for

changes that may occur prospectively regarding contract documents that will satisfy required conditions prior to contract execution.

#### Subchapter 11. Part-Time Employees Group

N.J.A.C. 17:9-11.3(a) is proposed for amendment to state “the State Managed Care Plan is defined at N.J.S.A. 52:14-17.26,” as it is incorrect to state that it is the plan currently listed; in addition, subsection (b) is proposed for amendment to state that members of the Part-Time Employees Group are permitted to select coverage under any of the plans that their employer offers, except the successor plan, any high deductible health plans with the employer, and an employee prescription drug program, if offered by a participating local employer. This group is no longer limited to only NJ DIRECT 15 coverage. Subsection (c) is proposed for amendment for the same reason, with the phrase, “eligible SHBP medical plan” replacing “NJ DIRECT 15.”

N.J.A.C. 17:9-11.10(a) and (c) are proposed for amendment by removing “NJ DIRECT 15,” as retired coverage can be under any eligible SHBP medical plan.

#### Subchapter 12. Retiree Dental Expense Plan

At N.J.A.C. 17:9-12.1(a), the phrase, “traditional indemnity-type plan” is proposed to be replaced with “PPO,” to use current language that more accurately describes the Dental Expense Plan operationally. In addition, the sentence “[r]etirees may also enroll in any of the DPOs offered” is proposed to be added, as enrollment in any of the DPOs offered is now open to retirees. Finally, paragraph (c)2 is proposed for deletion, as duplicate coverage is already prohibited for the health plans, so it is, therefore, not needed.

#### Subchapter 13. Chapter 375 Dependents

Chapter 375 dependent eligibility begins after age 26, rather than age 23, so the reference to the eligibility requirement of age in N.J.A.C. 17:9-13.1(a) is proposed for amendment accordingly. In addition, the enrollment application for a Chapter 375 dependent and the certificate of creditable coverage is to be submitted no later than 60 days after the dependent meets all eligibility criteria provided in N.J.A.C. 17:9-13.2(a), rather than 30 days (current practice), so N.J.A.C. 17:9-13.2(a)1 is proposed for amendment accordingly. In addition, the phrase, “unless proof is provided that other coverage was lost; in such cases, coverage is retroactive,” is to be added to paragraph (a)1, which also reflects current procedures.

#### Social Impact

Members, retirees, and dependents of the State Health Benefits Program rely on the efficient operation of the SHBP, and the presence and predictability of rules that guide the effective and efficient administration of their health benefits. Likewise, participating employers rely on the existence of efficient enrollment and payment procedures that are based on current statute and law. The protections and guarantees that these rules afford members, retirees, dependents, and employers of the State-administered retirement systems who participate mandate their continued existence. The taxpaying public is also affected by these rules, since public monies are used to fund the benefits. Therefore, taxpayers also benefit from the proper and efficient administration of the SHBP.

A number of changes affect the current rules at N.J.A.C. 17:9 significantly, resulting in both a positive and negative social impact. The Federal Patient Protection and Affordable Care Act affects the coverage requirements for children of subscribers. These requirements allow for coverage of children through the age of 26, even if they do not live with their parents or are not financially dependent upon them, which means that children can continue to be covered under the SHBP, even when they have no health benefits coverage through their own employment. This can be a significant benefit to subscribers and their children, as it provides important health coverage; however, the financial burden for taxpayers may also have a negative social impact when higher taxes are needed to pay for additional benefits.

#### Economic Impact

The efficient operation of the health plans administered by the State of New Jersey allows member benefits to be delivered and the employer reporting process to occur in a timely manner, thereby providing an invaluable benefit to members, retirees, dependents, and public

employers alike. The rules proposed for readoption with amendments, a repeal, and a new rule will continue existing, longstanding regulatory requirements, while also improving current policies and procedures and upholding newly passed laws and court decisions that impact the SHBP, such as the Federal PPACA. In addition, the rules will continue to provide for the effective and efficient delivery of health benefits, while also meeting new and existing statutory and contractual requirements, especially under the PPACA. Without the administrative rules to provide for the efficient operation of the SHBP, members, retirees, dependents, employers, and New Jersey’s taxpayers could be adversely affected.

The proposed readoption of the rules with amendments, a repeal, and a new rule could present adverse economic effects on the public in general, in that SHBP coverage must now be extended through the age of 26 for children of subscribers under the PPACA; however, with the exception of rising premium cost sharing, the Division is not aware of any hardship or costs imposed by the rules on the members of the SHBP themselves; in fact, coverage changes make more plans available to subscribers under the SHBP, allowing members to have more choice in the plan coverage and deductibles that available SHBP plans now offer.

#### Federal Standards Statement

There are no Federal requirements or standards that affect the subject of this rulemaking, except that there is reference to compliance with the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. §§ 1320d et seq., as well as compliance with the Federal Patient Protection and Affordable Care Act (PPACA), Pub. L. 111-148 and Pub. L. 111-152; however, these laws are not exceeded.

#### Jobs Impact

The operation of the rules proposed for readoption with amendments, a repeal, and a new rule will not result in the generation or loss of jobs. The rules have been in effect for many years, and have served to efficiently and effectively guide the Division in the operation and administration of the SHBP. The Division invites any interested parties to submit any data or studies concerning the jobs impact of these rules with their written comments.

#### Agriculture Industry Impact

The rules proposed for readoption with amendments, a repeal, and a new rule will not have an impact on the agriculture industry.

#### Regulatory Flexibility Statement

The rules affect members, retirees, and dependents enrolled in the SHBP. Thus, the rules proposed for readoption with amendments, a repeal, and a new rule do not impose any reporting, recordkeeping, or other compliance requirements upon small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Therefore, a regulatory flexibility analysis is not required.

#### Housing Affordability Impact Analysis

The rules proposed for readoption with amendments, a repeal, and a new rule will have no impact on the affordability of housing in New Jersey, nor will they evoke a change in the average costs associated with housing, because the rules pertain to administration of the SHBP for members, retirees, and dependents.

#### Smart Growth Development Impact Analysis

The rules proposed for readoption with amendments, a repeal, and a new rule will not have any impact on the achievement of smart growth; nor will they evoke a change in housing production in Planning Areas 1 or 2, or within designated centers, under the State Development and Redevelopment Plan because the rules pertain to the administration of the SHBP for members, retirees, and dependents of members and retirees.

**Full text** of the rules proposed for readoption may be found in the New Jersey Administrative Code at N.J.A.C. 17:9.

**Full text** of the rule proposed for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 17:9-3.5.

**Full text** of the proposed amendments and new rule follows (additions indicated in boldface **thus**; deletions indicate in brackets [thus]):

## SUBCHAPTER 1. ADMINISTRATION

## 17:9-1.2 Records

(a) The Secretary of the Commission shall maintain minutes of the Commission meetings in compliance with the **Senator Byron M. Baer Open Public Meetings Act (OPMA)**, N.J.S.A. [5:10-1] **10:4-6** et seq. Public session minutes are public records subject to access under the Open Public Records Act (OPRA), N.J.S.A. 47:1-1 et seq., and the requirements of the Federal Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. [§§3210d] **§§ 3210d** et seq. Minutes of closed sessions pertaining to the claims of any individual shall be redacted of all personal identifying information unless the individual member waives his or her privacy interest and consents in writing to disclosure in accord with HIPAA. Minutes of executive sessions shall be subject to disclosure pursuant to the OPMA after the Commission determines the need for confidentiality no longer exists. Records of the Commission subject to public access under OPRA may be inspected during regular business hours at the office of the Division under supervision of a representative of the State Health Benefits Program or other representatives of the office. All requests for records under OPRA shall be made in writing on the required form and submitted to the Department of the Treasury Government Records Unit.

(b) To protect the personal privacy of individual participants and their families, the mailing addresses of active and retired participants and all matters [related to] **regarding** an individual's files **that** relate[d] to an individual's coverage and claims shall be maintained as confidential. Protected health information shall not be released to any person, except as permitted under HIPAA in response to a valid HIPAA Authorization for Release of Information, in a form acceptable to the Division, as described in 45 CFR 164.508, or as otherwise authorized by HIPAA. The requesting party shall have the burden of demonstrating to the satisfaction of the Division that the confidential materials may be released under HIPAA.

## 17:9-1.3 Appeals from Commission decisions

(a) Any member of the SHBP who disagrees with the decision of the [claims administrator] **carrier** and has exhausted all appeals within the plan, **as well as any external review required by the PPACA, if applicable**, may request that the matter be considered by the Commission. Requests for consideration must be directed to the Secretary of the Commission **within one year of the plan's final adverse benefit determination**, and must contain the reason for the disagreement and all available supporting documentation. Appeals shall be considered at the regular meetings of the Commission. It shall be the responsibility of the member to provide the Commission with any medical or other information that the Commission may require in order to make a decision.

(b) Any person who disagrees with a determination made by the Division regarding their enrollment or eligibility in the SHBP, may request that the matter be considered by the Commission.

(c) (No change.)

(d) [Any] **If a** member [who] disagrees with the Commission's decision and submits the written statement [as] set forth in (c) above within 45 calendar days, [shall be notified] **the Commission shall determine whether to grant an administrative hearing on the basis of whether the matter involves contested facts or is solely a question of law. The Commission will then notify the member of the disposition of the appeal**, in one of two ways:]:

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

2. (No change.)

## 17:9-1.4 Employer participation

(a) An employer joining the SHBP must adopt the resolution furnished by the Division and must agree to comply with the statutes and rules adopted by the Commission. The effective date of coverage for employers with fewer than 250 employees, COBRA participants, and retired members will be the first day of the month following a period beginning 75 days after the receipt by the [Commission] **Division** of the completed resolution. The effective date of coverage for employers with 250 or more employees, COBRA participants, and retired members will be the first day of the month following a period beginning 90 days after the receipt by the [Commission] **Division** of the completed resolution.

(b)-(c) (No change.)

**(d) Before re-entry is permitted, an employer must satisfy all outstanding balances from previous participation.**

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

(a) (No change.)

(b) When a participating employer voluntarily terminates coverage, the coverage for the employer's active and retired employees, participants under N.J.S.A. 52:14-17.29k, and COBRA participants shall terminate as of the first of the month following a 60-day period beginning with the receipt of the resolution by the [Commission] **Division**.

(c)-(d) (No change.)

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

(a) A participating employer will be considered in default 31 days after the beginning of the coverage period for which charges were due. At that point, coverage may terminate for all members enrolled through the terminating employer. **The effective date of termination for the employer's active and retired employees, COBRA participants, and participants under N.J.S.A. 52:14-17.29k will be the first of the month after a 60-day period beginning the date the employer is considered in default.**

(b)-(c) (No change.)

## 17:9-1.7 Employer incentives for non-enrollment

(a) (No change.)

(b) Any participating local employer, other than the State, is allowed to pay an employee an incentive to waive coverage if that employee is eligible for other health coverage. [The incentive may be up to 50 percent of the amount saved by the employer in such a case. The employee may enroll immediately into the program if the other coverage or the waiver ends but must repay, on a pro rata basis, any amount received, which represents an advance payment for a period of time during which coverage is resumed. An employee who waives coverage under this rule is not precluded from continuing coverage into retirement.]

**1. For waivers filed on or after May 21, 2010 (the effective date of P.L. 2010, c. 2), the incentive shall not exceed \$5,000 or 25 percent of the amount saved by the employer because of the employee's waiver of coverage, whichever is less.**

**2. For waivers filed before May 21, 2010 (the effective date of P.L. 2010, c. 2), the incentive may be up to 50 percent of the amount saved by the employer.**

[(c) As the employer's certifying agent must sign each individual waiver application, no general resolution is required for the adoption of the waiver incentive.]

**(c) The employee may enroll immediately into the program if the other coverage or the waiver ends, for any reason, including, but not limited to, the retirement or death of the spouse or divorce. The employee must repay, on a pro rata basis, any amount received, which represents an advance payment for a period of time during which coverage is resumed.**

**(d) To waive coverage or resume coverage that has been waived, an employee must notify his or her employer, and both must notify the SHBP in writing by submitting a Coverage Waiver/Reinstatement for State Employees if employed by the State of New Jersey, or a Coverage Waiver/Reinstatement for Local Government/Educational Employees if employed by a local government or local education entity.**

**(e) If the member is waiving coverage because of other SHBP or SEHBP coverage, no monetary incentive is allowed.**

(f) No general resolution is required for the adoption of the waiver incentive, since the employer's certifying officer must sign each individual waiver application.

(g) An employee who waives coverage under this section is not precluded from continuing coverage into retirement.

#### 17:9-1.8 Definitions

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

"Carrier" means a voluntary association, corporation, or other organization, including, but not limited to, a health maintenance organization as defined in section 2 of the "Health Maintenance Organizations Act," P.L. 1973, c. 337 (N.J.S.A. 26:2J-2), which is lawfully engaged in providing or paying for, or reimbursing the cost of, personal health services, including hospitalization, medical, and surgical services under insurance policies or contracts, membership, or subscription contracts, or the like, in consideration of premiums or other periodic charges payable to the carrier.

"Category of coverage" means one of the options used for determining the rates for the premium or periodic charges for different levels of coverage under the program, which include single, [member] subscriber and spouse/partner, parent and child, and family coverage, and whether prescription drug coverage is provided in the health coverage. For retirees only, the category also reflects the Medicare entitlement of the [member] subscriber and spouse/partner.

"Chapter 375 Dependents" means all adult children[, which] who are defined as dependents in their parent's State health benefits coverage, pursuant to P.L. 2005, c. 375, and supplemented by P.L. 2008, c. 38, which is codified at N.J.S.A. 52:14-17.29k and N.J.A.C. 17:9-13.

"Civil union partner" means a person, who is of the same sex as the employee, with whom a legally recognized union is formed. The relationship must also satisfy the definition of a civil union as set forth in N.J.S.A. 37:1-2. Civil union certificates issued to same-sex couples from other jurisdictions are accepted under the New Jersey civil union statutes. Whenever reference is made to "marriage," "husband," "wife," "spouse," "family," "immediate family," "dependent," "next of kin," "widow," "widower," "widowed" or another word, which in a specific context denotes a marital or spousal relationship, the same shall include a civil union partner; or a domestic partnership [formed outside the State of New Jersey].

"COBRA" means the Federal Consolidated Omnibus Budget Reconciliation Act of 1985, [42] 29 U.S.C. [§§1161-1168] §§ 1161-1168, which requires most employers sponsoring group health plans to offer employees and their eligible dependents the opportunity to temporarily extend their group health coverage in certain instances where coverage under the plan would otherwise end.

["Dependent" refers to any individual covered under the SHBP in addition to the subscriber (see N.J.A.C. 17:9-4.1).]

"Dependent" means an employee's spouse, domestic partner, or partner in a civil union couple, and children under the age of 26 years, as well as unmarried disabled children age 26 or older who were covered by the SHBP upon reaching age 26 and who are not capable of self-support upon reaching the age 26 due to mental illness, mental incapacity, or a physical disability, and who remain substantially dependent on the subscriber for support and maintenance. "Children" shall include stepchildren, legally adopted children, and children placed by the Division of Child Protection and Permanency in the Department of Children and Families, provided they are reported for coverage and are wholly dependent upon the employee for support and maintenance. A spouse, domestic partner, partner in a civil union couple, or child enlisting or inducted into military service shall not be considered a dependent during the military service. The term "dependents" shall not include spouses, children, domestic partners, partners in a civil union couple, or children of retired persons who are otherwise eligible for the benefits under the State Health Benefits Program but who, although they meet the age or disability eligibility requirement of Medicare, are not covered by Medicare Hospital Insurance, also known as Medicare

Part A, and Medicare Medical Insurance, also known as Medicare Part B.

"Domestic partner" (as defined by N.J.S.A. 26:8A-3) or "eligible domestic partner" means a person, who is of the same sex as the employee, who is in a committed relationship with an employee of the State of New Jersey or with an employee of a SHBP participating location that has adopted by SHBP resolution, pursuant to N.J.S.A. 52:14-17.26, the definition of dependent that includes domestic partners. The relationship must also satisfy the definition of a domestic partnership as set forth in N.J.S.A. 26:8A-4, and the domestic partners must execute and file an Affidavit of Domestic Partnership with the local registrar. The resulting Certificate of Domestic Partnership must be provided to the SHBP, and Certificates of Domestic Partnership issued in New Jersey must be dated prior to February 19, 2007, pursuant to the limitations on domestic partnerships established under N.J.S.A. 26:8A-4.1. Marriage certificates issued to same-sex couples do not fall under the New Jersey Domestic Partnership statutes. Pursuant to N.J.S.A. 26:8A-11, this definition does not include the domestic partner of a participant in the SHBP who is the opposite sex of the participant. A public employer that does not participate in the SHBP may adopt this definition of domestic partner by filing a resolution for all of their retirees enrolled in the retired SHBP.

"Education Employer" means a local school district, regional school district, county vocational school district, county special services school district, jointure commission, educational services commission, State-operated school district, charter school, county college, any officer, board, or commission under the authority of the Commissioner of Education or of the State Board of Education, and any other public entity that is established pursuant to authority provided by Title 18A of the New Jersey Statutes, but excluding the State public institutions of higher education and excluding those public entities where the employer is the State of New Jersey.

"Eligible Employer" is a public agency, [the] whose employees [of which, if otherwise eligible,] may join any of the retirement systems established by statute to provide retirement benefits for public employees, if they are eligible. [The term does not apply to school employers or their employees.] The term "eligible employer" includes State employers, local employers, and education employers.

"Employee" means a person employed in any full-time capacity by an "eligible employer." "Full-time" shall have the same meaning as established under N.J.S.A. 52:14-17.26(c). The term "employee" shall not include persons employed on a short-term, seasonal, intermittent, or emergency basis, persons compensated on a fee basis, persons having less than two months of continuous service, or persons whose compensation is limited to reimbursement of necessary expenses actually incurred in the discharge of their official duties; however, the term "employee" shall include persons employed on an intermittent basis to whom the State has agreed to provide coverage under N.J.S.A. 52:14-17.25 et seq. (P.L. 1961, c. 49) in accordance with a binding collective negotiations agreement. An employee paid on a 10-month basis, pursuant to an annual contract, shall be deemed to have satisfied the two-month waiting period if the employee begins employment at the beginning of the contract year. The term "employee" shall also not include retired persons who are otherwise eligible for benefits under the State Health Benefits Program but who, although they meet the age or disability eligibility requirement of Medicare, are not covered by Medicare Hospital Insurance, also known as Medicare Part A, and Medicare Medical Insurance, also known as Medicare Part B. A determination by the Commission that a person is an eligible employee for the purposes of the State Health Benefits Program shall be final and binding on all parties.

"Medicare" means the program established by the "Health Insurance for the Aged Act," Title XVIII of the "Social Security Act," Pub.L. 89-97 (42 U.S.C. §§ 1395 et seq.), as amended, or its successor plan or plans.

“NJ DIRECT15” means the State’s managed care plan created by P.L. 2007, c. 103 as a replacement to the [“NJ PLUS”] **State’s former point of service plan coverage.**

[“NJ PLUS” is the name of the State’s Point of Service plan as defined in Section 2 (N.J.S.A. 52:14-17.26) of the Act.]

“SEHBP” means the **School Employees’ Health Benefits Program, which was established under P.L. 2007, c. 103, to govern the administration of health benefit plans and prescription drug coverage for eligible public local education employees and retirees and their eligible dependents.**

“Spouse” means a person [of the opposite sex] to whom one has been joined in a properly recorded legal ceremony authorized by law (as defined by N.J.S.A. 37:1-1). New Jersey recognizes legal marriages performed in other states or jurisdictions but does not recognize “common law” or any other form of marriage without a formal license (N.J.S.A. 37:1-10).

“State-administered pension fund” means a retirement system administered by the Division, including such systems as the Alternate Benefit[s] Program.

“State managed care plan” means a health care plan under which comprehensive health care services and supplies are provided to eligible employees, retirees, and dependents:

1. Through a group of doctors and other providers employed by the plan; or

2. Through an individual practice association, preferred provider organization, or point of service plan under which services and supplies are furnished to plan participants through a network of doctors and other providers under contracts or agreements with the plan on a prepayment or reimbursement basis and which may provide for payment or reimbursement for services and supplies obtained outside the network. The plan may be provided on an insured basis through contracts with carriers or on a self-insured basis, and may be operated and administered by the State or by carriers under contracts with the State.

High deductible plans are not included as “managed care plans.”

“Successor plan” means a managed care plan that replaces the Traditional Plan, as defined in section 2 of P.L. 1961, c. 49 (N.J.S.A. 52:14-17.26), and that provides an in-network level of benefits as set forth in section 36 of P.L. 2007, c. 103, as well as out-of-network benefits to participants [with a payment of 80 percent of reasonable and customary].

“Traditional plan” means a health care plan, which provides basic benefits, extended basic benefits, and major medical expense benefits as set forth in section 5 of P.L. 1961, c. 49 (N.J.S.A. 52:14-17.29) by indemnifying eligible employees, retirees, and dependents for expenses for covered health care services and supplies through payments to providers or reimbursements to participants. Termination of traditional plan coverage through the SHBP was effective on March 28, 2008, for State biweekly employees and March 31, 2008, for all State retirees and State monthly employees. For all local government employees and retirees, the effective date of termination was April 1, 2008.

## SUBCHAPTER 2. COVERAGE

### 17:9-2.1 Enrollment

An eligible employee [shall be eligible to] may enroll for coverage for the employee and the employee’s eligible dependents. The employee and any dependents must enroll in the same plan.

### 17:9-2.2 Enrollment form

(a) Within 60 days of the time an employee first becomes eligible to apply for coverage, the employee shall file a completed enrollment form indicating the employee’s election to enroll or not to enroll for coverage on the employee’s own behalf; and the employee’s election to enroll or not to enroll any eligible dependents for coverage under one of the SHBP options. A dependent must be listed on the enrollment form to be enrolled

for coverage. Appropriate legal documentation, as described in N.J.A.C. 17:9-3.3(a), verifying the dependent’s relationship with the subscriber is required before enrollment is approved. If more than 60 days have passed since first eligible for enrollment, then the enrollment form shall not be processed and will be returned to the employer. The employee may then file the enrollment form during the next open enrollment period with coverage to be effective according to the schedule for that open enrollment period.

(b) For Chapter 375 dependents, enrollment shall also occur in accordance with N.J.A.C. 17:9-13.2.

(c) For coverage dependents with disabilities, enrollment shall also occur in accordance with N.J.A.C. 17:9-3.4.

### 17:9-2.3 Annual open enrollment period

(a) Except as permitted under N.J.A.C. 17:9-2.4, any active employee or COBRA subscriber who did not elect to enroll for coverage for themselves or for their dependents at the time such employee or dependent first [becomes] became eligible for coverage shall subsequently be permitted to enroll themselves and their dependents only during the annual open enrollment period, with coverage effective according to the schedule for that open enrollment period.

(b)-(c) (No change.)

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

(a) An employee may change the employee’s enrollment and the enrollment of the employee’s dependents to any type of coverage if such changes result from a change in the family, dependency, or employment status of the employee or the employee’s dependents. Such changes will be permitted under the following conditions:

1. *Marriage[,] and civil unions [and eligible domestic partnerships].* Any employee who marries or enters into [an eligible domestic partnership or] a civil union may enroll the employee and eligible dependents, if any, for any appropriate type of coverage by applying for coverage within [the period beginning 60 days prior to the marriage, domestic partnership or civil union and ending] 60 days after such marriage[, domestic partnership] or civil union. In the event that the spouse or partner is already enrolled in the SHBP or SEHBP as an employee, the provisions of N.J.A.C. 17:9-3.5, regarding the prohibition of multiple coverage shall apply to such spouse’s or partner’s enrollment. A copy of the marriage certificate or certificate of [domestic partnership or] civil union must be submitted with the completed application to add the spouse/partner.

2.-4. (No change.)

5. *When last [dependent] covered child reaches age [23] 26, marries, or enters into a civil union prior to that time. On December 31 of the year in which the child reaches age 26, the child shall be removed from coverage by the SHBP and the level of coverage of the employee or retiree shall be adjusted accordingly, unless the child is otherwise eligible for continued coverage as an average child with disabilities.* Any employee who shall have enrolled one or more [dependent] children as dependents may enroll for any coverage at the time the last such [dependent] child reaches age [23] 26, marries prior to that time, enters into a domestic partnership or civil union or becomes otherwise ineligible, by completing and forwarding a new enrollment form.

6. *When last covered child obtains other group health coverage through employment, marriage, or upon entering into a civil union or domestic partnership prior to attaining age 26. Any employee who shall have enrolled one or more children will be removed from dependent coverage at the time the last such child obtains other health benefits through employment or marriage, or upon entering into a civil union or domestic partnership prior to attaining age 26, or becomes otherwise ineligible. A subscriber may complete and forward a new enrollment form to change coverage level.*

[6.] 7. *An employee, spouse, eligible domestic or civil union partner, or dependent ceases to be covered by other group health coverage. If the employee, spouse, domestic or civil union partner, or other dependent has other group health coverage, and then becomes ineligible for that other coverage due to qualifying events, such as termination of employment, divorce, termination of domestic or civil union partnership, death, or reduction in hours worked, the employee may enroll in any plan or for any coverage in the SHBP, provided that the employee submits a new*



enrollment application accompanied by proof of the prior coverage, within 60 days of the qualifying event.

[7.] **8. Birth, adoption, or guardianship of [dependent] children.** When an employee acquires qualified dependents through birth, placement for adoption, adoption, legal guardianship of children, or the assumption of direct support of children, the employee may enroll the employee and any eligible dependents for any appropriate type of coverage by completing and forwarding a new enrollment form within the period beginning 60 days prior to and ending 60 days after the birth, placement for adoption, the adoption, the guardianship, or the assumption of direct support of children. Such application regarding placement for adoption, adoption, assumption of direct support of children, and guardianship shall be accompanied by legal documentation evidencing the relationship.

[8. *A child resuming eligibility as a dependent child.* An employee may enroll, for any coverage, an otherwise eligible child under age 23 who, having previously been ineligible as a dependent child, resumes dependent status, resides with the parent and is financially dependent upon the parent. This applies to children whose marriage, civil union, or domestic partnership has been dissolved, as well as to children who had been considered independent by nature of employment. The employee and child must enroll in the same plan. An application for coverage shall be submitted within 60 days of the entry of a judgment of divorce or dissolution of the civil union or termination of the domestic partnership or the date the child ends employment in order to obtain coverage retroactively to the date of the re-qualifying event. Otherwise, enrollment shall be permitted only during an open enrollment.]

9. *COBRA enrollment.* When an employee or dependent enrolls in the COBRA group, the employee or dependent may, within 60 days of the qualifying event, select any plan. In order for an employee or dependent to enroll in health benefit, dental, or prescription coverage through COBRA, the subscriber must have been eligible for that coverage in the active group.

**i. A Chapter 375 dependent who thereafter becomes ineligible for group medical and prescription coverage under Chapter 375 is not eligible for group medical and prescription coverage under COBRA.**

**ii. Chapter 375 dependents are permitted to continue vision and/or dental coverage under COBRA at the time they enroll in group medical and prescription coverage under Chapter 375, because Chapter 375 does not provide vision or dental coverage.**

10.-11. (No change.)

(b)-(c) (No change.)

#### 17:9-2.8 Transfers

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

(b) (No change.)

#### 17:9-2.11 Out-of-network [NJ DIRECT] PPO and high deductible health plan; eligible charges at enrollment (local employees)

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

(b) For purposes of retiring members with local coverage, all eligible charges incurred by eligible retirees and their covered dependents from January 1 of a calendar year to the effective date of coverage will be considered toward satisfying the **out-of-network** deductibles and

coinsurance required under the [out-of-network NJ DIRECT coverage] plan.

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

### SUBCHAPTER 3. DEPENDENTS

#### 17:9-3.1 Dependents and children defined

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

"Children" includes stepchildren **living with the subscriber**, legally adopted children, children placed in the employee's custody pending adoption, foster children, and children of an eligible domestic or civil union partner who are substantially dependent upon the employee for support and maintenance. This includes children in a guardian-ward, legal relationship who are living with the employee.

"Dependents" means an employee's spouse, eligible domestic or civil union partner and the employee's [unmarried] children through the end of the calendar year in which they reach the age of [23] 26 years [who live with the employee in a regular parent-child relationship]. "Dependents" also means unmarried children and those not in a domestic partnership or civil union, covered by their parents under the SHBP prior to the attainment of age [23] 26, who:

1. (No change.)
2. Became so incapable prior to attainment of age [23] 26; and
3. (No change.)

["Living with" shall be defined so as to include children in the case of divorce or termination of a domestic partnership or civil union who may not actually be living with the covered parent, but where such covered parent is required to provide for the support and maintenance of such children, and the parent's application for dependent coverage is documented by a copy of an appropriate court order. Stepchildren and children of an eligible domestic or civil union partner must reside with the employee.]

#### 17:9-3.3 Certification of dependency

(a) An employee who elects to enroll an eligible dependent for any coverage shall report such dependent's relationship or status on the enrollment form and provide appropriate legal documentation for each dependent to be enrolled, verifying the dependent's relationship with the subscriber. Examples of acceptable documentation, **as provided on the Division's website as Required Documentation for SHBP/SEHBP Dependent Eligibility and Enrollment**, include birth certificates, [sworn affidavits,] marriage certificates, certificates of domestic partnership or civil union, divorce and separation decrees, custody agreements, and court orders. This list is not meant to be all inclusive and does not imply acceptance of any of the above without proper authentication. [Such listing of the dependent shall constitute the required certification that at the time of enrollment such dependent is substantially dependent upon the employee for support and maintenance.]

(b) A person who, although listed as an eligible dependent, is found to be ineligible, shall be removed from coverage by the SHBP and the level of coverage of the employee or retiree shall be adjusted accordingly. Coverage for that person as a dependent shall be restored if acceptable documentation is provided to the Division, by the employee, or retiree, within 60 days of written notification of the dependent's termination. If acceptable documentation is received after 60 days, the dependent shall not be restored retroactively and can only be added at the next permissible enrollment opportunity.

#### 17:9-3.4 Children with disabilities age [23] 26 or older; determination of eligibility for continuation of coverage

(a) The determination as to the continuation of certain children with disabilities as "dependents" as defined by N.J.A.C. 17:9-3.1 shall be made by the SHBP's medical advisors. A form requesting continuance of enrollment for an eligible dependent with disabilities must be submitted to the SHBP no later than January 31 of the year following the calendar year in which the child attained the age of [23] 26.

(b) Children with disabilities who are age [23] 26 or older at the time their parents obtain coverage under the SHBP who are determined by the SHBP's medical advisors to be incapable of self-sustaining employment by reason of mental or physical disabilities and who meet the requirements of "dependents" as defined by N.J.A.C. 17:9-3.1, shall not be enrolled for coverage as "dependents" as defined by N.J.A.C. 17:9-3.1, unless:

1.-2. (No change.)

**(c) SHBP or SEHBP coverage for an overage child with disabilities must be continuous. If the member waives coverage or removes the child from coverage for any reason, the child may not be added again at a later date. This includes cases where an employee waives active coverage and resumes coverage as a retiree.**

#### 17:9-3.5 Multiple coverage prohibited

**(a) Multiple coverage under the SHBP/SEHBP as an employee, dependent, or retiree shall be prohibited, in accordance with N.J.S.A. 52:14-17.31.**

1. No employee shall have coverage as both a subscriber and a dependent in any plan offered by the SHBP/SEHBP.

2. No subscriber or dependent shall have both active and retired coverage under the SHBP/SEHBP.

3. If both parents of eligible children are participating subscribers of the SHBP/SEHBP, only one may cover the children; children are not eligible for coverage under both SHBP/SEHBP-covered parents.

**(b) Waivers of coverage are permitted as provided under N.J.S.A. 52:14-17.31(a) and N.J.A.C. 17:9-1.7.**

**(c) Health coverage for an overage dependent will be denied in cases where a member has waived coverage and the waiver of coverage is in effect at the time the overage dependent attains the age of 26.**

#### SUBCHAPTER 4. EMPLOYEES

##### 17:9-4.1 State employee defined

(a) For purposes of State coverage, "employee" shall mean an appointive or elective officer or full-time employee of the State [including] or, for those enrolled in the SHBP on or after May 21, 2010, a full-time appointive or elective officer or a full-time employee of the State whose hours are fixed at 35 or more hours per week. **Employees of the State shall include** employees of:

1.-2. (No change.)

[3. University of Medicine and Dentistry of New Jersey;]

**3. University Hospital;**

4.-6. (No change.)

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

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

1.-2. (No change.)

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

[4. Public defenders who are paid on the basis of an average 30-hour work week schedule, notwithstanding N.J.A.C. 17:9-4.4;

5. Employees of the University of Medicine and Dentistry of New Jersey who are paid for a minimum of 20 hours per week, notwithstanding N.J.A.C. 17:9-4.4; and

6. Teaching assistants and graduate assistants at Rutgers, the State University, who are paid for a minimum of 15 hours, notwithstanding N.J.A.C. 17:9-4.4.]

(b) (No change.)

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

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

1.-2. (No change.)

3. A rate per meeting[,] or session (payroll compensation code 8);

4.-6. (No change.)

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

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

1. Employment of any eligible employees who appear on a regular payroll and who receive a salary or wages for an average of the number of hours per week as prescribed by the governing body of the participating employer. Each participating employer shall, by resolution, determine the number of hours worked, which shall be considered to be "full-time." In no case shall the number of hours for "full-time" be less than [20] 25.

2.-3. (No change.)

(b) (No change.)

#### SUBCHAPTER 5. CHARGES

##### 17:9-5.2 Charges; interest charges

(a) By adoption of the appropriate resolution, the employer may request a premium delay of 30 or 60 days after the customary due date for such charges. If the employer terminates participation, any amounts outstanding must be paid with the final billing. **An employer who requests re-entry but has an outstanding balance from previous participation will not be granted a premium delay.**

(b)-(c) (No change.)

##### 17:9-5.4 Local employer resolution; P.L. 1974, c. 88; P.L. 1979, c. 54; P.L. 1999, c. 48

(a) A local employer will satisfy the requirements of P.L. 1974, c. 88, by adopting a resolution designed to:

1.-3. (No change.)

4. Require the local employer to pay [the full cost of NJ DIRECT or HMO] **all or some of the health benefits costs for retiree coverage if other conditions are met; P.L. 2011, c. 78, also requires local retirees who attain 25 years of service credit on or after June 28, 2011, to pay a percentage of the premium based on their retirement allowance; and**

5. (No change.)

(b)-(e) (No change.)

##### 17:9-5.5 Medicare refunds

(a) Where the State, directly or indirectly, reimburses the retiree for the Medicare Part B charges:

1. (No change.)

2. As Medicare Part B premium reimbursements are dependent upon sufficient annual appropriations from the [legislature] **Legislature**, eligible reimbursements [regarding] **for** Medicare Part B premiums will include only those premiums that have been paid for the period up to 12 months immediately preceding receipt of proof of Medicare and not those paid prior to the 12 months immediately preceding receipt of proof of full Medicare entitlement.

3. (No change.)

4. Where the reimbursement cannot be added to the retirement allowance, a separate check for the reimbursement will be mailed to the retiree **annually for the Medicare Part B payments paid in the previous year; for ABP members, the reimbursement is mailed monthly.** All reimbursements made for Medicare Part B shall be made payable to the retiree.

(b)-(c) (No change.)

(d) In no event shall duplicate reimbursements be made to any retiree for the retiree or the retiree's spouse or eligible domestic or civil union partner. If the spouse or eligible partner of a retiree receives reimbursement for Medicare Part B by the State in their retirement allowances, then the spouse or partner shall only be eligible for the Medicare Part B reimbursement based upon their employment and not the retiree's employment. Spouses or partners reimbursed directly by their employer and not through the State must submit proof that they have waived that other Medicare Part B reimbursement in order to be reimbursed as a spouse or partner of the retiree. In addition, the retiree is not eligible to receive reimbursement for the difference between the amounts reimbursed to a spouse or partner from [other] **another** Medicare Part B reimbursement and the amounts reimbursed to the retiree under the SHBP.

(e) (No change.)

## 17:9-5.6 Refunds rejected

Any request for refund not specified in N.J.A.C. 17:9-[3.5 and]5.5 shall be denied. For example, [a member and spouse or eligible partner may be employed in the same or in different locations, each location participating in the SHBP and both having family coverage, or both having member and spouse/partner coverage; in spite of the apparent duplication of coverage, neither of the covered employees would be eligible for a refund. Or, the spouse or eligible partner carries only single employee coverage under the State program while the member is covered by a plan in private industry where the employer pays for employee and dependent coverage; no refund would be payable since both would have to have been in public employment covered by the SHBP. Or,] if one spouse or eligible partner applies for Medicare reimbursement for the member and spouse or eligible partner, the other shall not receive duplicate reimbursement.

## 17:9-5.9 Health Contribution for active employee State Health Benefit Coverage

(a) Pursuant to P.L. 2007, c. 103[,] and P.L. 2011, c. 78 (N.J.S.A. 52:14-17.28[b]c), a [deduction in the amount of] **health contribution that is determined as a specific percentage of the cost of health care coverage for each salary range and coverage level specified in N.J.S.A. 52:14-17.28c**, shall be [made for] **deducted from each covered State [employee, as negotiated.] employee's base salary. The health contribution that is deducted may not be less than 1.5 percent of base salary.**

(b) For purposes of this section, base salary means an employee's annual base salary, not including any bonuses, overtime, or longevity payment.

## SUBCHAPTER 6. RETIREMENT

## 17:9-6.1 Retired employee defined

(a) "Retired employee" means a person who is eligible for coverage under the SHBP's retiree group. This "retired employee" status, once established, shall continue in effect even [though] **if** the employer is subsequently disbanded and no successor agency is created upon the dissolution of such employer.

(b) The definition of "retired employee" also includes the following classes of retired employees who are eligible for coverage:

1.-2. (No change.)

3. Retired employees of educational and county college employers, regardless of the employer's participation in the SHBP who:

i.-ii. (No change.)

iii. Retired on disability retirements or on benefits based upon 25 or more years of service credit in the Teachers' Pension and Annuity Fund, the Public [Employee's] **Employees'** Retirement System, the Alternate Benefit[s] Program or in a locally administered pension fund established by N.J.S.A. 18A:66-94 et seq. under the provisions of P.L. 1987, c. 384, P.L. 1992, c. 126, or P.L. 1995, c. 357 (N.J.S.A. 52:14-17.32f, 52:14-17.32f1, and 52:14-17.32f2, **respectively**);

4.-8. (No change.)

(c) "Retired employee" also means an employee whose coverage terminated prior to retirement, if that employee is awarded a disability retirement allowance **under the PFRS, SPRS, or JRS, or under the PERS or TPAF, if enrolled prior to May 21, 2010.** Eligibility for retired coverage in the SHBP shall begin on the employee's retirement date, but should the approval of the retirement allowance be delayed, coverage shall not be retroactive for more than one year.

(d)-(g) (No change.)

(h) **The definition of "retired employee" shall also include an employee who enrolled in the PERS or TPAF on or after May 21, 2010, and who is approved for long-term disability benefits under P.L. 2010, c. 3, provided the member meets all other eligibility requirements.**

Recodify existing (h)-(j) as (i)-(k) (No change in text.)

[(k)] (l) The employer liability for payments on behalf of eligible retired employees, which includes those employees who are eligible to receive long-term disability benefits, is payable in accordance with the provisions of N.J.S.A. 52:14-17.32, [and] 52:14-17.38, **18A:66-39.1, and 43:15A-42.1.**

## 17:9-6.3 Retiree coverage; limitation

(a) (No change.)

(b) Retired employees[,] whose retirement allowance is less than the charge to be deducted to pay for the cost of the coverage for such retired employees[,] will be permitted to continue coverage, provided that the retired employee pays for the cost of such coverage in advance on a monthly basis[.]; in [which] **such cases**, there will be no health benefit deduction from the retirement allowance.

(c) (No change.)

(d) A retired employee or dependent[,] who has maintained coverage in the SHBP following retirement and is subsequently removed from such coverage for not having the Federal Medicare Parts A and B coverage, as required by statute, will be permitted to obtain prospective reentry into the SHBP once proof of Federal Medicare Part A and B coverage has been provided to the Division.

(e) In the event a retired employee or any dependent of a retired employee enrolls in a **non-SHBP** Medicare Part D plan, SHBP retiree prescription drug benefits shall immediately terminate for the retired employee and all dependents. However, enrollment in a **non-SHBP** Medicare Part D plan by a retired employee or any dependent of a retired employee will not affect the continuation of SHBP medical plan benefits for the retired employee and any dependent of the retired employee.

(f) In the event a retired employee or dependent of a retired employee has enrolled in a **non-SHBP** Medicare Part D plan, the retired employee and dependent(s) will be prospectively enrolled or re-enrolled for SHBP retiree prescription drug benefits provided:

1. (No change.)

2. The retired employee and, if applicable, the retired employee's dependent, terminate[s] **non-SHBP** Medicare Part D plan coverage.

## 17:9-6.8 Premium-sharing for retired employee State Health Benefit Coverage and reimbursement for Medicare Part B costs

(a) All State employees, except nonaligned uniformed State Police officers, who accrue 25 years of service credit in a State-administered retirement system or retire on a disability retirement after July 1, 1997, for whom there is no majority representative for collective negotiations purposes, and who were hired by the State prior to July 1, 1995, **and were continuously employed**, shall, upon retirement, receive Medicare Part B reimbursement after retirement up to a cap of \$46.10 per month per eligible employee and the employee's spouse or eligible partner and be subject to payroll deductions for coverage in advance of the coverage period in accordance with standard payroll procedures as set forth below. State employees, except nonaligned uniformed State Police officers, who accrue 25 years of service credit in a State-administered retirement system or who retire on a disability retirement after July 1, 1997, for whom there is no majority representative for collective negotiations purposes, and who were hired by the State on or after July 1, 1995, shall not be entitled to receive Medicare Part B reimbursement after retirement.

(b) For employees hired before December 11, 1995, who accrue 25 years of service credit in a State-administered retirement system or retire on a disability retirement after July 1, 1997 but before July 1, 2000, payroll deductions for NJ DIRECT10 **or Aetna Freedom 10** coverage shall be determined using a base salary as of the first pay period of the calendar year in which retirement occurred, as follows:

1. Upon retirement, retirees with a base salary of \$40,000 or more in the year of retirement shall pay the difference between the cost of the NJ DIRECT10 **or Aetna Freedom 10** and the average cost for NJ DIRECT15 and participating HMOs, as determined hereinafter.

2. Upon retirement, retirees with a base salary of less than \$40,000 in the year of retirement shall pay, on a monthly basis, one percent of the base salary but not less than \$20.00 per month.

(c) Employees hired on or after December 11, 1995, who accrue 25 years of service credit in a State-administered retirement system after July 1, 1997 but before July 1, 2000, or retire on a disability retirement after July 1, 1997 but before August 1, 2000, shall, upon retirement, pay the difference between the cost of NJ DIRECT10 **or Aetna Freedom 10** and the average cost to the State for [NJ DIRECT15 and] **the other participating [HMOs] plans**, as determined hereinafter.

(d) The average cost for NJ DIRECT15 and **other** participating [HMOs] **plans** for each category of coverage for a rate time period shall be determined as follows:

1. Multiply the number of retirees who elected the category of coverage at the beginning of the rate time period immediately preceding the current rate time period by the premium or periodic charge rate for the category of coverage for the current rate time period for NJ DIRECT15 and each **other** participating [HMO] **plan**.

2. Determine the total premium and periodic charges for all retirees who elected the category of coverage by adding the amounts determined under (d)1 above for NJ DIRECT15 and the **other** participating [HMOs] **plans**.

3. Divide the total premium and periodic charges for all retirees who elected the category of coverage determined under (d)2 above by the total number of retirees who elected the category of coverage at the beginning of the immediately preceding rate time period for NJ DIRECT15 and the **other** participating [HMOs] **plans**.

(e) For retirees who accrue 25 years of service credit in a State-administered retirement system on or after July 1, 2000 but before June 30, 2007, or retire on a disability retirement after July 1, 2000 but on or before July 1, 2007, payroll deductions for NJ DIRECT10 or **Aetna Freedom 10** coverage shall be determined as follows:

1. Retirees electing NJ DIRECT10 or **Aetna Freedom 10** shall pay 25 percent of the cost of that plan's premium as established by the Commission pursuant to N.J.S.A. 52:14-17.32b;

2. Retirees electing [NJ DIRECT15 or an HMO] **other plans** shall have no premium payment.

[3.] (f) [For] State retirees who accrue 25 years of service credit in a State-administered retirement system on or after July 1, 2007 **but before June 30, 2011**, or retire on a disability retirement [on or] after July 1, 2007 **but before June 30, 2011**, shall pay a health contribution for [NJ DIRECT15 or HMO] **post-retirement health coverage. For most plans, except as specified under N.J.S.A. 52:14-17.28, the retiree will pay a health contribution of 1.5 percent of their retirement allowance, as negotiated, or 1.5 percent of 50 percent of the highest salary received in the last five years of employment for Alternate Benefit Program members. The health contribution is waived for retirees who participate in the Retiree Wellness Program.**

1. Retirees **who are eligible** must elect to participate in the Retiree Wellness Program within 60 days of the date of retirement.

2. If the Retiree Wellness Program is not elected within this time period, the retiree will be required to pay the health contribution of 1.5 percent of the retirement benefit.

3. Retirees not electing to participate in the program when first eligible may elect to participate in the Retiree Wellness Program only during the Division's annual open enrollment.

(g) State retirees who accrue 25 years of service credit in a State-administered retirement system after June 30, 2011, and have 20 years of service credit as of that date, shall have a health contribution of 1.5 percent of their retirement allowance deducted for their post-retirement health benefits coverage for most plans, except as specified under N.J.S.A. 52:14-17.28c. This health contribution will not be waived, even for those who participate in the Retiree Wellness Program.

(h) State retirees who retire on a disability retirement or accrue 25 years of service credit in a State-administered retirement system on or after June 28, 2011, and do not meet the conditions of (g) above, shall have a health contribution deducted from their retirement allowance for their post-retirement health benefits coverage, pursuant to N.J.S.A. 52:14-17.28c. The health contribution is determined as a specific percentage of the premium, and is based on the member's annual retirement allowance and coverage level. A minimum contribution of 1.5 percent of the monthly retirement allowance is required.

[(f)] (i) (No change in text.)

[(g)] (j) Independent State authorities, boards, commissions, corporations, agencies, or organizations who are excluded from determining by means of a binding collective negotiations agreement the payment obligations of the employer to pay the premium or periodic charges for SHBP coverage in retirement under the provisions of N.J.S.A.

52:14-17.38, and who are permitted by N.J.S.A. 52:14-17.28b to have their active employees premium share in the same manner as the State, may also have their retired employees premium share in the same manner as the State. The payment obligations of an employee under this subsection shall be the payment obligations applicable to the employee on the date the employee retired on a disability pension (**if enrolled on or before May 21, 2010, for PERS and TPAF members**) or the date the employee meets the service credit and service requirements for employer payment for the coverage, as the case may be.

(k) **A member with less than 25 years of service credit upon retirement will be offered retired SHBP coverage but must pay the full cost of post-retirement health benefits coverage, in addition to meeting all other eligibility requirements.**

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

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

1. (No change.)

2. Retired on a benefit based on 25 or more years of service credit or on a disability retirement under the PFRS, CPFPF, or PERS;

3.-4. (No change.)

(b) Pursuant to P.L. 1997, c. 330 (N.J.S.A. 52:14-17.32i et seq.), a qualified retiree and his or her eligible dependents, as defined in section 2 of P.L. 1961, c. 49 (N.J.S.A. 52:14-17.26), but not survivors, are eligible to participate in the SHBP in accordance with the laws and rules governing the program, regardless of whether the retiree's employer participated in the program, and for State payment of an amount of the premium or periodic charges for the category of coverage elected by the qualified retiree equal to 80 percent of the premium or periodic charges for that category of coverage under the **least expensive premium for a 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)-(f) (No change.)

(g) **A qualified retiree is required to make a minimum contribution of 1.5 percent of the retiree's monthly retirement allowance.**

(h) **Employers are not permitted to reimburse an eligible retired member for the member's share of the Chapter 330 coverage costs; members who receive such a reimbursement will be disqualified from receiving coverage under N.J.S.A. 52:14-17.32i.**

17:9-6.10 Retiree prescription drug plan

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

"Other brands" means prescription drug products that 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.

"Preferred brands" means brand name prescription drug products and insulin determined by the provider, to be more [cost effective] **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] **State Health Benefits Program Plan Design Committee.**

"Prescription drug plan" means the plan **or plans** for providing payment for eligible prescription drug expenses [of retired members of the] **for all State Health Benefit[s] Program retirees** and their eligible dependents who participate in the [Traditional Plan or the State managed care plan (NJ Plus)] **PPO, HMO, high deductible health plans, or other SHBP health plans offered to subscribers, as prescribed by this section. [Upon the effective date of the contracts to implement the**

successor or replacement plans for the Traditional Plan and NJ PLUS pursuant to the provisions of P.L. 2007, c. 103, "prescription drug plan" shall mean the plan or plans providing payment for eligible prescription drug expenses for all State Health Benefit Program retirees and their eligible dependents.]

["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) Reimbursement for the co-payments required under the prescription drug plan shall not be made under the medical portion of any SHBP plan. [There shall be no annual deductible amount that retired members or their eligible dependents shall satisfy before eligibility for payment of prescription drug expenses under the prescription drug plan.]

(c) (No change.)

(d) A co-payment shall be required for each prescription drug expense until a retired member or eligible dependent satisfie[d]s 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	Retail	Mail-Order
<u>Product</u>	<u>Pharmacy</u>	<u>Pharmacy</u>
Generic	\$ 5.00	\$ 5.00
Preferred Brands	\$ 10.00	\$ 15.00
Other Brands	\$20.00	\$25.00]

**Co-payment amounts in effect for the current year for generics, preferred brands, and other brands, as well as maximum annual out-of-pocket expenses, are provided on the Division of Pensions and Benefits website.**

(e) (No change.)

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

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

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

(i) (f) 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] **posted to the Division's website annually.**

(j) (g) The provider administering the prescription drug plan shall comply with N.J.A.C. [11:4-37.3(c)1 through 4, 6 and 7] **11:22-5** in the administration of the prescription drug plan:

**1. The provider shall follow the standards and procedures required to obtain approval for its prescription drug plan offerings and utilize selective contracting arrangements that promote health care cost containment while adequately preserving quality of care, pursuant to N.J.A.C. 11:4-37.1 and 37.2.**

**2. The provider shall follow the standards established for selective contracting arrangements, pursuant to N.J.A.C. 11:4-37.3.**

**3. The provider shall follow selective contracting arrangement approval and amendment procedures, pursuant to N.J.A.C. 11:4-37.4.**

(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.

(l) For calendar year 2006 (January 1, 2006 through December 31, 2006), the out-of-pocket maximum expense limit shall be equivalent to \$ 1,000. For each calendar year thereafter the out-of-pocket maximum expense limit shall be recalculated pursuant to the provisions of (h) above.]

SUBCHAPTER 7. TERMINATION

17:9-7.1 Termination effective date

(a)-(b) (No change.)

(c) Unless the subscriber requests termination of coverage, SHBP coverage for a member who is awaiting approval of a retirement benefit shall continue until the retirement is either approved or denied provided the member makes the appropriate remittance for coverage. Any retroactive SHBP premiums owed by the subscriber shall be deducted from the retirement benefit when approved, the withdrawal check, the return of pension contributions, or from any retirement or death benefit received by the member's [surviving dependent] **named beneficiary(ies).**

17:9-7.2 Termination of eligibility

(a)-(c) (No change.)

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

1.-4. (No change.)

5. [The dependent] **A covered child becomes eligible for SHBP or SEHBP coverage due to employment, unless the child waives that coverage in order to continue coverage as a dependent under a parent's SHBP plan.**

SUBCHAPTER 8. EMPLOYEE PRESCRIPTION DRUG PLAN

17:9-8.1 Employee Prescription Drug Plan

(a)-(b) (No change.)

(c) The rules for eligibility and for determining the effective dates of coverage are the same as those of the SHBP as administered by the 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. 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 SHBP medical plans.

i. If the employer elects to offer [a free-standing prescription drug plan] **the State Employee 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. (No change.)
- 3. (No change.)

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.]

SUBCHAPTER 9. EMPLOYEE DENTAL PLANS

17:9-9.1 Employee Dental Plans

(a) The Employee Dental Plans were established under the provisions of N.J.S.A. 52:14-17.29(F) and were extended to local participating employers as of January 1, 2005. The Employee Dental Plans are available to full-time employees and their eligible dependents. Newly eligible employees may enroll by completing an application during the first 60 days of employment. The Employee Dental Plans offer a choice between two types of dental plans[:]; a Dental Expense Plan and a Dental Plan Organization (DPO). The Dental Expense Plan is a [traditional indemnity-type plan which] **PPO** that allows the employee to select any licensed dentist for dental care. The Dental Plan Organizations (DPOs) are companies that contract with a network of providers for dental services. The employee must use providers participating with the DPO selected.

- (b) (No change.)

(c) The rules are the same as those of the SHBP as administered by the Commission in accordance with the provisions of N.J.S.A. 52:14-17.25 et seq., with the following exceptions:

[1. Duplicate coverage is not permitted; an individual may be covered as an employee or as a dependent or retiree, but not as both an employee and a dependent or retiree. Dependent children may only be covered by one parent;]

Recodify existing 2.-4. as **1.-3.** (No change in text.)

[5.] **4.** If an employer elects to participate in the Employee Dental Plans, the employee's share of the cost for the Plans may be determined by a formula different from that used to determine the employee's share of the cost of health coverage[, provided that the employer's portion of the total premium cost for the Plans shall not be less than 50 percent]. The employee may pay a share of the cost of dental coverage for the employee and for the employee's covered dependents as required by a collective negotiations 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 collective negotiations agreement;

Recodify existing 6. and 7. as **5. and 6.** (No change in text.)

SUBCHAPTER 10. PROCUREMENT OF STATE HEALTH BENEFITS PROGRAM CONTRACTS

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:

...  
 ["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.]

"Best and final offer" or "BAFO" means a price timely submitted by a bidder upon invitation by the Division after proposal opening, with or without prior discussion or negotiation.

...  
 "Bid security" means a guarantee, in a form acceptable to the Division, acting on behalf of the Commission, that the bidder, if selected, will accept the contract as bid; otherwise, the bidder or, as applicable, its guarantor will be liable for the amount of the loss suffered by the State, which loss may be partially or completely recovered by the State in exercising its rights against the instrument of bid security.

"Bidder" means a vendor who has offered a proposal in response to the solicitation of proposals by the Division, on behalf of the Commission.

"Business registration" means the formal certification by the Department of the Treasury's Division of Revenue that a business entity, upon its application to the Division of Revenue, has attained and maintained status as a registered business in accordance with the provisions of N.J.S.A. 52:32-44.

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

...  
 ["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.]

"Competitive range" means the group of responsive proposals that are among the most highly rated proposals.

"Contract" means a mutually binding legal relationship obligating the contractor to furnish goods and/or services and the purchaser to pay for them, subject to appropriation where the using agency derives its annual budget by means of appropriation from the State Legislature. For publicly advertised contracts, the contract consists of standard terms and conditions, the RFP, the responsive proposal, the notice of acceptance or award, any subsequent written document memorializing the agreement, any amendments or modifications to any of these documents and any attachments, addenda, or other supporting documents, or other agreed-upon writings describing the work to be performed.

"Contract documentation" refers to paperwork verifying that the selected bidder has satisfied the conditions precedent to contract execution. Examples include, but are not limited to: 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.

...  
 ["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.]

"Contractor" refers to a business entity awarded a contract.

"Day" or "business day" means [business day, not including] any weekday, excluding Saturdays, Sundays, [or a] State legal holidays, and State-mandated furlough days.

"Director" refers to the Director of the Division of Pensions and Benefits or the Director's designee.

...  
 "Filed" means received by the Director or the Director's Division representative.

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

"Hearing officer" means the Commission's representative from within or outside the Division, but independent of the procurement process, appointed by the Commission to review the written record of

an advertised procurement, and/or, in the discretion of the Commission, to preside over an in-person presentation or informal hearing in response to a vendor's challenge, in accordance with N.J.S.A. 52:34-10.10.

"Negotiation component" refers to an RFP provision that establishes the intent of the Division, on behalf of the Commission, to negotiate with bidders pursuant to the provisions of N.J.S.A. 52:34-12(f), the codified generic procedures set forth at N.J.A.C. 17:12-2.7, and the specified provisions for negotiation set forth in the RFP.

"Performance security" means a guarantee, executed subsequent to award, in [the] a form [of a deposit or a bond, submitted by the selected] acceptable to the Division, on behalf of the Commission, that the successful bidder [subsequent to the Notice of Intent to Award and prior to contract execution, that the selected bidder] will complete the contract as agreed and that the [Commission] State will be protected from loss in the event the [selected bidder] contractor fails to complete the contract as agreed.

"Protest" refers to a timely filed challenge to a specification in an advertised RFP, to a rejection of a proposal declared non-responsive, [of a Request for Proposal requirement] or to [the Commission's] a contract award decision.

"Request for Proposal" or "RFP" refers to all documents, whether attached or incorporated by reference, used for a publicly advertised procurement process that [soliciting bid] solicits proposals [for] or offers to provide the goods and/or services specified therein.

"Responsible bidder" refers to a [bidder who has demonstrated] bidding entity deemed to have integrity and [the capability to successfully provide the services being procured] to be reliable and capable of performing all contract requirements.

"Responsive proposal" refers to a proposal that is deemed to have adequately addressed all material provisions of an RFP's terms and conditions, specifications, and other requirements.

"Sealed bidding" means bidding in which the contents of proposals cannot be opened or viewed before the formal opening of proposals, without leaving evidence that the document has been opened or viewed.

"Signed" means a physical or electronic signature evincing a bidder's intent to be bound.

#### 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, as set forth in N.J.A.C. 17:12, shall govern.

### SUBCHAPTER 11. PART-TIME EMPLOYEES GROUP

#### 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 participating in the SHBP, are eligible to enroll if they are members of [the] a State-administered retirement system.

#### 17:9-11.3 Coverage available

(a) The State Managed Care Plan is [NJ DIRECT15] as defined at N.J.S.A. 52:14-17.26.

(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 [NJDIRECT15] any plan that the member's employer offers, excluding the successor plan, any high deductible health plans with the employer, and an employee prescription drug program offered by a participating local employer. Members shall also be eligible for coverage under the State Employee Prescription Drug Plan. [There shall be no prescription drug coverage under NJ DIRECT15.]

(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 DIRECT15] an eligible SHBP medical plan.

(d) (No change.)

#### 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 DIRECT15] immediately prior to retirement shall be eligible to continue [NJ DIRECT15] coverage as a retiree at their own expense. Prescription drug benefits shall be provided through the Retiree Prescription Drug Card Plan (N.J.A.C. 17:9-6.10).

(b) (No change.)

(c) An eligible surviving spouse or eligible partner will be offered the opportunity to continue participation [in NJ DIRECT15] 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 or eligible partner must pay the full costs.

### SUBCHAPTER 12. RETIREE DENTAL EXPENSE PLAN

#### 17:9-12.1 Retiree Dental Expense Plan

(a) The Retiree Dental Expense Plan (Plan) was established under the provisions of N.J.S.A. 52:14-17.29(F) and became effective as of January 1, 2005. The Plan is available to retirees eligible for participation in the SHBP and School Employees' Health Benefit Program and their eligible dependents. New retirees may enroll by completing an application at the time of retirement. The Plan [is] includes a Dental Expense Plan, which is a [traditional indemnity-type plan, which] PPO that allows the employee to select any licensed dentist for dental care. Retirees may also enroll in any of the DPOs offered.

(b) (No change.)

(c) The rules are the same as those of the SHBP as administered by the Commission in accordance with the provisions of N.J.S.A. 52:14-17.25 et seq., with the following exceptions:

1. Coverage is not continued in the event of termination from the SHBP. There is no eligibility to continue retired dental coverage under the Federal COBRA law; and

2. Duplicate coverage is not permitted; an individual may be covered as a retiree or as an employee or dependent but not as both a retiree and a dependent or retiree or employee. Dependent children may only be covered by one parent; and]

[3.] 2. (No change in text.)

#### 17:9-12.3 Plan progressive coinsurance design

(a) The Plan has three progressive coinsurance tiers. The highest tier provides a greater percentage of reimbursement for reasonable and customary charges than the lower two tiers. Each year a retiree remains a member of the Plan, the coinsurance tier rises until the retiree reaches the highest tier.

1. A retiree who was enrolled in a group dental plan immediately [proceeding] preceding eligibility for coverage in the Plan, and who was covered under a group dental plan for at least one year within 60 days of joining this Plan, is eligible for enrollment at the highest tier of reimbursement.

2. A retiree who was not enrolled in a group dental plan for at least one year immediately [proceeding] preceding eligibility for coverage in the Plan shall be enrolled in the lowest tier of reimbursement.

3. (No change.)

(b) (No change.)

### SUBCHAPTER 13. CHAPTER 375 DEPENDENTS

#### 17:9-13.1 Eligibility criteria

(a) In order for a dependent to qualify for and remain eligible for SHBP coverage after age [23] 26 as a Chapter 375 dependent, the dependent must be a covered person's child by blood or law who:

1.-5. (No change.)

17:9-13.2 Enrollment

(a) Enrollment of a Chapter 375 eligible dependent is voluntary. A separate election will be required for enrollment, change in, or a voluntary termination of coverage for a Chapter 375 eligible dependent. If an employee or retiree (subscriber) does not elect coverage for a Chapter 375 eligible dependent by December 31, 2007, the subscriber may thereafter enroll the dependent as follows:

1. Submission of an enrollment application and certificate of creditable coverage to the Division no later than [30] 60 days after the dependent meets all eligibility criteria under N.J.A.C. 17:9-13.1. Coverage will be effective the first coverage period of the month, 60 days after the dependent meets all eligibility criteria, **unless proof is provided that other coverage was lost; in such cases, coverage is retroactive.**

2. In the event a subscriber does not submit an enrollment application to the Division within [30] 60 days after the dependent meets all eligibility criteria under N.J.A.C. 17:9-13.1, the subscriber can only enroll the dependent during the annual October open enrollment period. If the dependent meets all eligibility criteria, coverage will be effective the first coverage period in January, following the open enrollment period.

(b) (No change.)

(a)

**OFFICE OF THE STATE TREASURER  
Offset of State Lottery Prizes to Satisfy Defaulted  
Federal and State Student Loans  
Proposed Readoption: N.J.A.C. 17:43**

Authorized By: Ford M. Scudder, Acting State Treasurer,  
Department of the Treasury.

Authority: N.J.S.A. 5:9-13.10 through 5:9-13.16.

Calendar Reference: See Summary below for explanation of  
exception to calendar requirement.

Proposal Number: PRN 2016-075.

Submit written comments by July 15, 2016, to:

Megan R. Mazzoni, Esq.  
Deputy Director, Administration and Compliance  
Division of Lottery  
PO Box 041  
Trenton, NJ 08625-0041  
or electronically at [megan.mazzoni@lottery.nj.gov](mailto:megan.mazzoni@lottery.nj.gov)

The agency proposal follows:

**Summary**

In order to provide ample notification, the public comment period will be extended to 60 days, since the proposed readoption of this chapter is not listed in the agency calendar. This notice of proposal is excepted from the rulemaking calendar requirement pursuant to N.J.A.C. 1:30-3.3(a)5.

Pursuant to Executive Order No. 66 (1978) and N.J.S.A. 52:14B-5.1, N.J.A.C. 17:43 is scheduled to expire on May 4, 2016. As the Office of the State Treasurer has submitted this notice to the Office of Administrative Law prior to that date, the expiration date is extended 180 days to October 31, 2016, pursuant to N.J.S.A. 52:14B-5.1.c(2). The Office of the State Treasurer, the Division of State Lottery and the Higher Education Student Assistance Authority (HESAA) have reviewed the rules proposed for readoption and determined them to be necessary, reasonable, and proper for the efficient administration of the procedures therein to offset State lottery prizes to satisfy defaulted Federal and State student loans for which they were originally promulgated, as required by the Executive Order. To ensure the continued efficient administration of this State lottery offset, the Office of the State Treasurer is proposing the readoption of this chapter to satisfy defaulted Federal and State student loans.

The rules proposed for readoption provide for a match of lists of winners of lottery prizes in excess of \$1,000 with lists of individuals who are in default of a student loan. The match is to be based on lists maintained by the Division of State Lottery in the Department of the Treasury and HESAA. No lottery prize in excess of \$1,000 will be

disbursed until a comparison has been made and a resolution of any debt is satisfied.

If a match is found, HESAA is required to notify the lottery winner that payment of the prize is being withheld and that the individual may request a hearing on the debt. If the individual does not request a hearing, the lottery prize will be applied to the debt prior to the disbursement of the remainder of the lottery prize. If the individual requests a hearing, the resolution of the hearing process will determine whether or not the lottery prize will be applied to the debt. If the defaulted loan is subject to a judgment, the lottery prize will be applied to satisfy the judgment prior to the disbursement of the remainder of the lottery prize. If the debtor appeals the judgment, the resolution of the appeal will determine whether or not the lottery prize will be applied to the debt.

**Social Impact**

The rules proposed for readoption will enhance the ability of the State to collect defaulted Federal and State student loans. Defaulted student loans negatively impact access to low cost student loans since the Federal government has to increase Federal spending to cover the costs of defaulted student loans, and since the State student loan program will have less to lend to students if it has to use bond proceeds to cover the costs of defaults. Therefore, providing the State another collection tool can help safeguard the student loan funds that facilitate access to higher education.

**Economic Impact**

The rules proposed for readoption will have a positive economic impact on the loan funds that HESAA will have available for students who wish to borrow since repayments of defaulted loans will continue to be made through the State lottery offset. In accordance with P.L. 1997, c. 306, the costs of administering the act and this chapter will be borne by the Division of Lottery, Office of Information Technology (OIT), and HESAA. The administrative cost of the program is estimated to be nominal. The operating costs will continue with no need for additional staff. Lottery winners whose prizes are subject to the offset will have their prizes reduced by the offset amount.

**Federal Standards Statement**

N.J.A.C. 17:43-1.4 contains a stipulation that for lottery prizes of more than \$5,000, Federal income tax withholding will take precedence over any other setoffs, deductions, or set asides under this chapter. This precedence for Federal income tax withholding is required by section 1942 of the Energy Policy Act, which amends Internal Revenue Code § 3402(q); Reg. §§ 31.3402(q)-1 and 1.6011-3. There are no other Federal laws or regulations that impact the rules proposed for readoption. N.J.A.C. 17:43 is based on State statute, which establishes authority for this chapter. Therefore, a Federal standards analysis is not required.

**Jobs Impact**

The rules proposed for readoption will not result in either the creation of new jobs or the loss of existing jobs.

**Agriculture Industry Impact**

The rules proposed for readoption will not have any impact on the agriculture industry.

**Regulatory Flexibility Statement**

A regulatory flexibility analysis is not required because the rules proposed for readoption do not impose reporting, recordkeeping, or other compliance requirements on small businesses as defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The rules proposed for readoption govern only the administrative operations of State agencies relative to individuals who have won lottery prizes in excess of \$1,000 and who have defaulted on student loans.

**Housing Affordability Impact Analysis**

The Division of State Lottery anticipates that the rules proposed for readoption will have no impact on any aspect of housing, as the rules establish procedures for the offset of State Lottery prizes to satisfy defaulted Federal and State student loans.

**Smart Growth Development Impact Analysis**

The rules proposed for readoption would not result in a change in the housing production within Planning Areas 1 or 2, or within designated