(c) Applications for Certificates of Registration and Banner Permits may be obtained on weekdays between 9:00 A.M. to 5:00 P.M. by contacting:

Real Estate and Economic Development
One Penn Plaza East
Newark, NJ 07105
Telephone: (973) 491-7451 or (973) 491-8078
Fax: (973) 491-7331

Applications can be sent to the requester by postal mail, electronic mail, or telefax.

16:83-2.2 Application for Certificates of Registration

(a) The application for a Certificate of Registration, signed by the applicant, shall contain the following:

1.-2. (No change.)

3. The name(s) and title(s) of the individual(s) who will have supervision of and responsibility for the non-commercial expressive conduct at the specified facility during the term of the Certificate; and

4. (No change.)

16:83-2.3 Validity of Certificates of Registration

(a) Each Certificate of Registration (Certificate) shall be valid for the date(s) and time(s) appearing on the approved Certificate. A Certificate shall be valid for up to, but not more than, five days. A Certificate shall not be valid prior to 6:00 A.M. or after the closing time of the facility. If the facility does not close, the Certificate shall be valid only until 10:00 P.M. of the date(s) appearing on the Certificate.

(b) Each Certificate shall be valid only for the person(s) designated by NJ TRANSIT on that Certificate. Certificates are not transferable.

(c) NJ TRANSIT may limit the number of valid Certificates to the maximum number of individuals established for the particular facility, as indicated on the map or rider attached to each Certificate, taking into account the public transportation purposes and staffing levels of the facility.

(d) Certificates shall be valid only at the facility or facilities specified on the Certificate.

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

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.

16:83-2.7 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.)

16:83-2.12 Banner installation, maintenance and removal

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

(c) 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

Readoption with Amendments: N.J.A.C. 17:9

Adopted Repeal and New Rule: N.J.A.C. 17:9-3.5

Proposed: May 16, 2016, at 48 N.J.R. 784(a).
Adopted: September 29, 2016, by the State Health Benefits Commission, Kierney Corliss, Acting Secretary.
Filed: September 29, 2016, as R.2016 d.146, **without change**.

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

Effective Dates: September 29, 2016, Readoption;
November 7, 2016, Amendments, Repeal, and New Rule.
Expiration Date: September 29, 2023.

Summary of Public Comments and Agency Responses:

A private citizen identified only as Jean Public submitted one set of comments by e-mail on May 23, 2016, as presented below.

COMMENT: The commenter states that full-time hours for State Health Benefits Program (SHBP) eligibility should be 35 hours per week for all members, not 20 or 25 hours per week as allowed for some employees of local public employers. The commenter notes that most employees in the private sector must work 40 hours per week in order to have full-time status. The commenter asserts that State government workers "need to have their hours increased to be more standard with private employers, nobody gives you 35 hours per week." Further, the commenter states that "this imposition on State taxpayers is outrageous since it means paying much higher pay scales for much less work than is being secured in private industry."

RESPONSE: As the commenter correctly points out, the minimum hours that must be worked in order to be eligible for SHBP coverage are different for State employees and local employees. While State employees are required to work at least 35 hours per week to be eligible for SHBP coverage, pursuant to N.J.A.C. 17:9-4.1(a), local employees must work a minimum of 25 hours per week, in accordance with N.J.A.C. 17:9-4.6. However, the minimum hours that must be worked per week to be eligible for SHBP coverage are already established in current statute, at N.J.S.A. 52:14-17.26. Therefore, it would require legislative action to change the parameters for eligibility for SHBP coverage, such as the minimum number of hours to be worked. The regulatory process is not the proper legal avenue for repealing current statutes, such as those that dictate the minimum hours worked per week required for SHBP coverage eligibility.

COMMENT: The commenter asserts that taxpayers should only pay for partial health benefits for employees. They should not be required to pay for health benefits for the employees' spouses or other dependents, as health benefit costs have increased substantially. The commenter believes that the State's public employees should assume the cost of health coverage for their spouses themselves.

RESPONSE: While the commenter is correct in stating that health care costs continue to rise and taxpayers must bear some of the burden for these rising costs, public employees have also been required to pay more for their health care coverage, in the form of higher biweekly or monthly premium payments, higher copayments, and in some cases, higher deductibles.

In addition, since statute (N.J.S.A. 52:14-17.26) specifically identifies the dependents who are permitted to receive health coverage through an employee's SHBP membership, legislative action would be required to change the SHBP's dependent coverage provisions. The regulatory process is not the proper legal avenue for amending the dependent eligibility requirements for health care coverage available through a public employee's membership.

COMMENT: The commenter states that the negative social impact on the State's taxpayers resulting from "the continual pressure by State employees to get more and more" is enormous. The commenter also asks how taxpayers can pay for such liberal benefits when some have little to nothing or can't get steady jobs; the unemployment rate in some neighborhoods is 50 percent. The commenter asserts that the "out-of-control spending by State legislators to pay for votes from the state employee bloc has made for a corrupt situation. The giving of benefits seems to be a vote-getting episode for State legislators these days. Some consideration for taxpayers is needed but there has been none in 20 years."

RESPONSE: The proposed regulations at N.J.A.C. 17:9 are intended to provide for the proper administration of the State Health Benefits Program, based on statutes that currently exist or have been enacted recently. For this reason, rules that contradict existing statutory provisions regarding the SHBP cannot be adopted. Changes to statute must first occur, through the required legislative process.

Furthermore, as the cost of health benefits coverage provided to public employees at both the State and local level has risen, those public employees have had to assume a greater responsibility for that cost, in the form of higher premiums, copayments, and deductibles over time. In 2011, member contributions to the State Health Benefits Program were $233,187,835, but by 2012, they stood at $244,680,394, which represents an increase of over $11 million in one year (State of New Jersey State Health Benefit Program Funds, 2013). Between 2013 and 2014, member contributions rose from $304,860,078 to $399,307,467, representing an increase of over $94,000,000 (State of New Jersey State Health Benefit Program Funds, 2014). This means that from 2011 to 2014, member contributions rose by over $166 million. From this data it is apparent that members continue to assume a greater financial responsibility for the cost of their SHBP coverage. It is also important to note that in addition to State employees and retirees (including New Jersey's State Troopers), public employees and retirees at the local level, including police officers, firefighters, and municipal works, are also covered under the SHBP, in cases where their employing location has, by resolution, elected to participate in the SHBP.

COMMENT: The commenter further asserts that the 25 years to retirement needs to be changed to one date of retirement, at 67 years of age, like Social Security. The commenter states, "These out-of-control benefits from 1950 need to be updated to what the bulk of society is getting when they work. We cannot continue to have gold-plated benefits for State employees just because they are insiders. That is unfair, evil, malicious government."

RESPONSE: The proposed rules at N.J.A.C. 17:9 are intended to provide for the proper administration of the State Health Benefits Program, based on statutes that currently exist or that have been enacted recently. They include the requirements for eligibility for active and retired health care coverage under the SHBP, as already stipulated in existing statute. Rules that will contradict present statutory provisions regarding the SHBP cannot be proposed or adopted. Changes to statute must occur through the required legislative action.

Further, the proposed SHBP rules do not dictate retirement provisions for public employees. Retirement provisions are found in the rules and statutes for retirement that have been adopted for each fund, system, or program, as applicable. Instead, the proposed SHBP rules provide the rules and requirements for active and retired health care coverage under the SHBP, which are also based on existing statute. When an SHBP (or SEHBP) member attains 25 years of public service, the member may become eligible for full or partial State-paid health benefits under the SHBP (or SEHBP). The eligibility requirements for those benefits are already provided in statute and may not be changed using the regulatory process.

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. §§ 1302d et seq., as well as compliance with the Federal Patient Protection and Affordable Care Act (PPACA), Pub. L. 111-148 and Pub. L111-152; however, these laws are not exceeded.

Full text of the readopted rules can be found in the New Jersey Administrative Code at N.J.A.C. 17:9.

Full text of the adopted amendments and new rule follows:

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. 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 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 regarding an individual's files that relate 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 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) If a member disagrees with the Commission's decision and submits the written statement set forth in (c) above within 45 calendar days, 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.

1. 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 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 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 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.

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) 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, 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 subscriber and spouse/partner.

"Chapter 375 Dependents" means all adult children 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.

"COBRA" means the Federal Consolidated Omnibus Budget Reconciliation Act of 1985, 29 U.S.C. §§ 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" 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, whose employees may join any of the retirement systems established by statute to provide retirement benefits for public employees, if they are eligible. 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 State's former point of service plan coverage.

…

"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 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 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.

"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 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 overage 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 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.* Any employee who marries or enters into a civil union may enroll the employee and eligible dependents, if any, for any appropriate type of coverage by applying for coverage within 60 days after such marriage 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 civil union must be submitted with the completed application to add the spouse/partner.

2.-4. (No change.)

5. *When last covered child reaches age 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 overage child with disabilities. Any 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, 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.

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.

8. *Birth, adoption, or guardianship of 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.

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 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 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 plan.

(c) The charges considered are to be eligible charges under 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 children through the end of the calendar year in which they reach the age of 26 years. "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 26, who:

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

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, 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.

(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 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 26.

(b) Children with disabilities who are age 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 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 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.

(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 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 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, eligible reimbursements 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 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. 17:9-5.5 shall be denied. For example, 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. 52:14-17.28c), a 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 deducted from each covered State 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 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 Employees' Retirement System, the Alternate Benefit 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.)

(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, 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 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 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 the other participating plans, as determined hereinafter.

(d) The average cost for NJ DIRECT15 and other participating 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 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 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 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 other plans shall have no premium payment.

(f) 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 after July 1, 2007 but before June 30, 2011, shall pay a health contribution for 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.

(i) (No change in text.)

(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.

(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 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 State Health Benefits Program Plan Design Committee.

"Prescription drug plan" means the plan or plans for providing payment for eligible prescription drug expenses for all State Health Benefit Program retirees and their eligible dependents who participate in the PPO, HMO, high deductible health plans, or other SHBP health plans offered to subscribers, as prescribed by this section.

…

(b) Reimbursement for the co-payments required under the prescription drug plan shall not be made under the medical portion of any SHBP plan.

(c) (No change.)

(d) A co-payment shall be required for each prescription drug expense until a retired member or eligible dependent satisfies the maximum annual out-of-pocket expense for a calendar year. 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) 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 posted to the Division's website annually.

(g) The provider administering the prescription drug plan shall comply with N.J.A.C. 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.

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 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. 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 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 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.

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 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:

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

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. 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" 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" 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 responsive proposal that is most advantageous to the State is not the lowest priced responsive proposal.

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"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.

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

"Day" or "business day" means any weekday, excluding Saturdays, Sundays, 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.

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

"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.

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"Performance security" means a guarantee, executed subsequent to award, in a form acceptable to the Division, on behalf of the Commission, that the successful bidder will complete the contract as agreed and that the State will be protected from loss in the event the 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, or to 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 solicits proposals or offers to provide the goods and/or services specified therein.

"Responsible bidder" refers to a bidding entity deemed to have integrity and to be reliable and capable of performing all contract requirements.

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"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.

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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 a State-administered retirement system.

17:9-11.3 Coverage available

(a) The State Managed Care Plan is 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 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.

(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 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 immediately prior to retirement shall be eligible to continue 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 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 includes a Dental Expense Plan, which is a 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. (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 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 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 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 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 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.)