DEPARTMENT OF THE TREASURY
John E. McCormac, CPA
State Treasurer

DIVISION OF PENSIONS AND BENEFITS
Frederick J. Beaver
Director

STATE HEALTH BENEFITS PROGRAM OF NEW JERSEY COMMISSION

Commission as of June 30, 2002

JOHN E. McCORMAC
State Treasurer
Chairperson

Holly Bakke
Commissioner
Department of Banking and Insurance

Ida L. Castro
Commissioner
Department of Personnel

Frederick J. Beaver
Secretary

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

October 2002

TO THE HONORABLE
JAMES E. McGREEVEY
GOVERNOR of the STATE OF NEW JERSEY

Dear Governor McGreevey:

As Secretary to the New Jersey State Health Benefits Commission and Director of the Division of Pensions and Benefits, I am pleased to present the Fiscal Year 2002 Annual Report in accordance with the provisions of N.J.S.A. 52:14-17.27.

The Division has been working to improve our services and benefits to members and participating employers.

In the Fiscal Year 2002 the Health Benefits Bureau initiated Open Enrollment e-seminars over the Internet to pre-registered State and Local participating Human Resources Representatives to view web-based presentations with an interactive audio narration providing details on the upcoming Open Enrollment period and on changes, updates and plan designs available through the New Jersey State Health Benefits Program. Web-based presentations for employees or employers were available 24 hours per day, 7 days per week during this period.

The Traditional Plan and NJ PLUS were improved with the addition of prescription drug coverage for retirees. The new prescription drug plan became effective January 2002, and included a mail order feature and a three-tiered copayment design with a maximum annual copay of $300.00 per retiree. The copayments and annual copayment maximum formula are designed to increase over time as costs increase. The prescription drug plan offered by participating HMO's was changed to a three-tier copayment design.

A subscriber pay-all voluntary Long Term Care Insurance Program available to state employees, retirees and family members, had a successful debut in Fiscal Year 2002 with a positive and better than expected enrollment response.

We will continue to pursue new and innovative benefit designs and concepts that will enhance the care to our members while continuing to contain health costs for all concerned.

Respectfully submitted,

FREDERICK J. BEAVER
Secretary

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NEW JERSEY STATE HEALTH BENEFITS PROGRAM

Mission and Vision

Mission

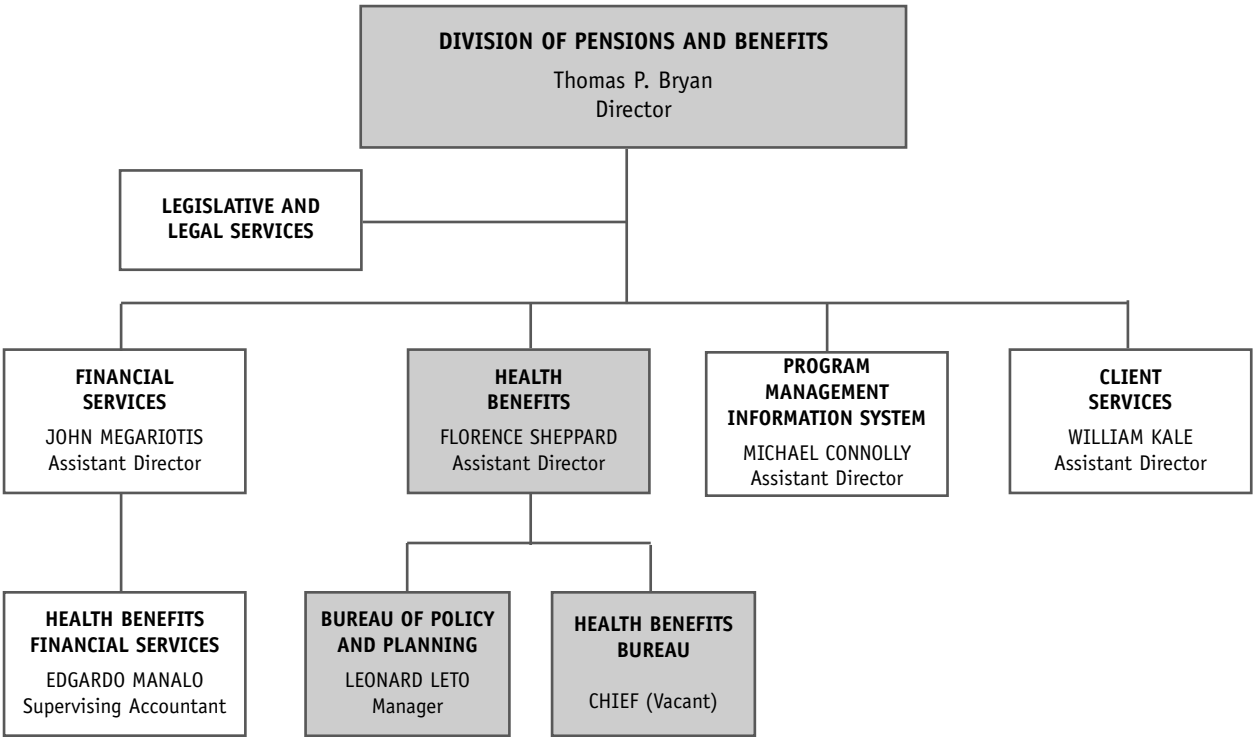
The State Health Benefits Program is committed to a standard of excellence that delivers quality health care in an efficient and cost effective manner.

Vision

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

STATE HEALTH BENEFITS PROGRAM AND RELATED SERVICES

Organization Chart as of June 30, 2002



NEW JERSEY STATE HEALTH BENEFITS PROGRAM

Overview

The State Health Benefits Program (SHBP) offers a variety of health plans for the more than 750,000 active and retired New Jersey public sector employees and their dependents. The SHBP consists of two distinct groups - the State Group and the Local Employer Group that includes entities such as boards of education, municipalities, counties, etc.

The responsibility for the operations of the SHBP resides with the Director of the Division of Pensions and Benefits. The Division is part of the State's Department of the Treasury. The policy-making body of the SHBP is the State Health Benefits Commission. The Commission consists of the State Treasurer, the Commissioner of the Department of Banking and Insurance, and the Commissioner of the Department of Personnel. The Treasurer serves as the Chair of the Commission. All decisions made by the Commission are a matter of public record.

Health Benefits is composed of two bureaus under the direction of an Assistant Director.

Health Benefits Bureau

The Health Benefits Bureau is responsible for all SHBP enrollment activities encompassing 8 medical plans, 11 dental plans, and a prescription drug plan. In addition, the Bureau is responsible for the administration of benefits under the federal COBRA law.

Bureau of Policy and Planning

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

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

History

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

Chapter 337 of the Public Laws of 1973 (C.26:2J-3) authorized the establishment of Health Maintenance Organizations to be offered to both State and local employers. The first HMO enrollment took place in 1976.

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

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

The State Dental Program was established February 1, 1978 for State employees only. Initially only one plan was offered: a traditional indemnity plan known as the New Jersey State Dental Expense Benefits Program. The Program expanded in June 1984 to include Dental Provider Organizations (DPOs). All eligible State employees may enroll for themselves and their eligible dependents by paying the premium calculated to meet half of the cost of the program.

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

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

Medical Plans Offered

NJ PLUS

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

Traditional Plan

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

Health Maintenance Organizations (HMOs)

Choices include comprehensive coverage where employees choose a primary care physician from a closed network of participating providers to manage all care provided. Most HMOs cover the entire State and adjacent counties in neighboring states where licensed. For Medicare eligible retirees, all State participating HMOs coordinate their benefits with Medicare.

Dental Program

State employees may choose a traditional indemnity plan called the Dental Expense Plan or a prepaid Dental Provider Organization, a dental HMO. Dental coverage is optional. State employees who opt for coverage pay 50% of the monthly cost through payroll deductions. Dental coverage is not available to State retirees or to employees or retirees of local employers.

Prescription Drug Program

Employee Prescription Drug Plan

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

The Prescription Drug Plan is currently administered by Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) through Merck-Medco, L.L.C., and its affiliate, PAID Prescriptions, L.L.C.

For each 30-day supply obtained at a retail pharmacy, participants pay a $1.00 co-payment for generic drugs and a $5.00 co-payment for brand name drugs. Members may purchase up to a 90-day supply of medication at a pharmacy when prescribed by a provider, by paying applicable copayments (60-day supply-two copayments, 90-day supply-three copayments).

A mail order program is also available. When mail order is used, up to a 90-day supply of medication has a $1.00 copayment for generic drugs and a $5.00 copayment for brand name drugs.

Retiree Prescription Drug Plan

Effective 2002, all retirees became covered under a separate three-tiered prescription drug card plan. HMO prescription drug coverage also included mail order service.

Plan Changes

Aggregate of Service Credit

Upon retirement, a State employee, board of education employee, or county college employee who has 25 or more years of service credit, is eligible for State-paid health benefits under the SHBP. An employee of a local government who has 25 or more years of service credit and whose employer is enrolled in the SHBP at retirement and has chosen to provide post-retirement medical coverage, is eligible for employer-paid health benefits in retirement under the SHBP. Effective August 15, 2001, the 25 years of service credit does not have to be from a single retirement system, and must not be concurrent.

Chiropractic Care Benefit

Effective January 1, 2002, both the Traditional Plan and NJ PLUS cover a maximum of 30 visit per person per calendar year.

Retiree Prescription Drug Card Program

Retirees enrolled in the Traditional Plan or NJ PLUS have access to a separate prescription drug card plan that includes a mail order service. The program features a three-tiered copayment design.

Administrative Services Contract

The SHBP awarded the Traditional Plan and NJ PLUS Administrative Services Contract to Horizon Blue Cross/Blue Shield.

HMOs

The SHBP approved a three-tiered pharmacy benefit when drug coverage is provided by an HMO.

HMOs

The SHBP requires NCQA accreditation as a requirement for SHBP participation.

2002 Significant Legislation

CHAPTER 189, P.L. 2001

This law extends similar health benefit waiver provisions applicable to municipal employers under Chapter 259, P.L. 1995 to municipal authorities. Unlike Chapter 259, which applied to municipalities that participated in either the SHBP or another group health plan, this law only applies to municipal authorities that participate in the SHBP.

The law pertains to any municipal authority created by a municipality under either the municipal sewerage authorities law, N.J.S.A.40:14A-1 et seq., or the municipal and county utilities authority law, N.J.S.A.40:14B-1 et seq. A municipal authority that participates in the State Health Benefits Program (SHBP), may allow any employee who is eligible for coverage as a dependent of the employee's spouse under that program or under another health benefits plan offered by the spouse's employer, whether a public or private employer, to waive the SHBP coverage to which the employee is entitled by virtue of employment with the municipal authority. In consideration of filing such a waiver, a municipal authority may pay to the employee annually an amount, to be

established in the sole discretion of the authority, which shall not exceed 50% of the amount saved by the authority because of the employee's waiver of coverage. Current law permits any municipality participating in SHBP to offer such a waiver incentive.

Under this law, an employee who waives coverage will be permitted to immediately resume coverage if the employee ceases to be covered through the employee's spouse for any reason, including, but not limited to, the retirement or death of the spouse or divorce. An employee who resumes coverage will repay, on a pro rata basis, any amount received from the municipal authority which represents an advance payment for a period of time during which coverage is resumed.

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

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

CHAPTER 200, P.L. 2001

This law requires providers of most health benefits plans that include prescription drug coverage to issue to their insured members an identification card containing standardized pharmacy information.

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

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

(1) the insured's identification number;

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

(3) if required for proper claims adjudication,

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

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

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

The law provides that a plan provider need not issue a special pharmacy identification card to an insured who has already been issued a general plan member identification card containing the information required under the

law. Also, it allows providers to use data elements that are required by State or federal regulations adopted under the federal "Health Insurance Portability and Accountability Act of 1996" ("HIPAA") in place of the information required under the law.

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

The Commissioner of Banking and Insurance shall adopt rules and regulations to administer this act.

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

CHAPTER 209, P.L. 2001

This law amends the statutes governing a retiree's eligibility for paid coverage under the State Health Benefits Program (SHBP).

Previously, the law provided that to qualify for such coverage, a State employee or an employee of a board of education or county college (other than one retiring on a disability pension) must have accrued 25 years of service credit in a single State-administered retirement system. A local government unit in SHBP may choose to provide post-retirement medical coverage to its retirees, but with certain exceptions, a local government retiree must have accrued 25 years of creditable service in a single State or locally-administered retirement system to qualify.

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

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

CHAPTER 227, P.L. 2001

This law clarifies the requirements of P.L.1995, c.415, which requires health insurers that cover groups of 51 or more persons and health maintenance organizations to provide benefits for Pap smears. This law stipulates that the required health insurance coverage shall include coverage for any confirmatory test, when medically necessary and as ordered by the woman's physician, and all laboratory costs associated with the initial Pap smear and any such confirmatory test. The purpose of the law is to assist those patients who have found that their health insurance benefits for Pap smears, as mandated by State law, did not fully cover all of the costs addressed by this law.

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

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

CHAPTER 284, P.L. 2001

This law requires the State Health Benefits Program to ensure that any person covered under the program who is enrolled in a health maintenance organization or the NJ PLUS, will be provided with 90-days notice if that person's primary care physician will be terminated from the provider network by the plan. If 90-days notice can-

not be provided because the termination will occur prior to the end of the 90-day period, the health maintenance organization or NJ PLUS must notify the member as soon as the health maintenance organization or NJ PLUS has knowledge of the termination. Upon receiving such notification, the covered person shall be permitted to change coverage to another health benefits plan, even though the physician's termination may occur outside of the annual open enrollment period.

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

CHAPTER 367, P.L. 2001

This law applies to health care carriers which offer a managed care plan that provides for both in-network and out-of-network benefits. It requires a carrier to reimburse a health care facility for the services provided by the facility at the carrier's full contracted rate without any penalty for the patient's selection of an out-of-network health care provider, in accordance with the in-network policies and in-network copayment, coinsurance or deductible requirements of the managed care plan. This is so even if:

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

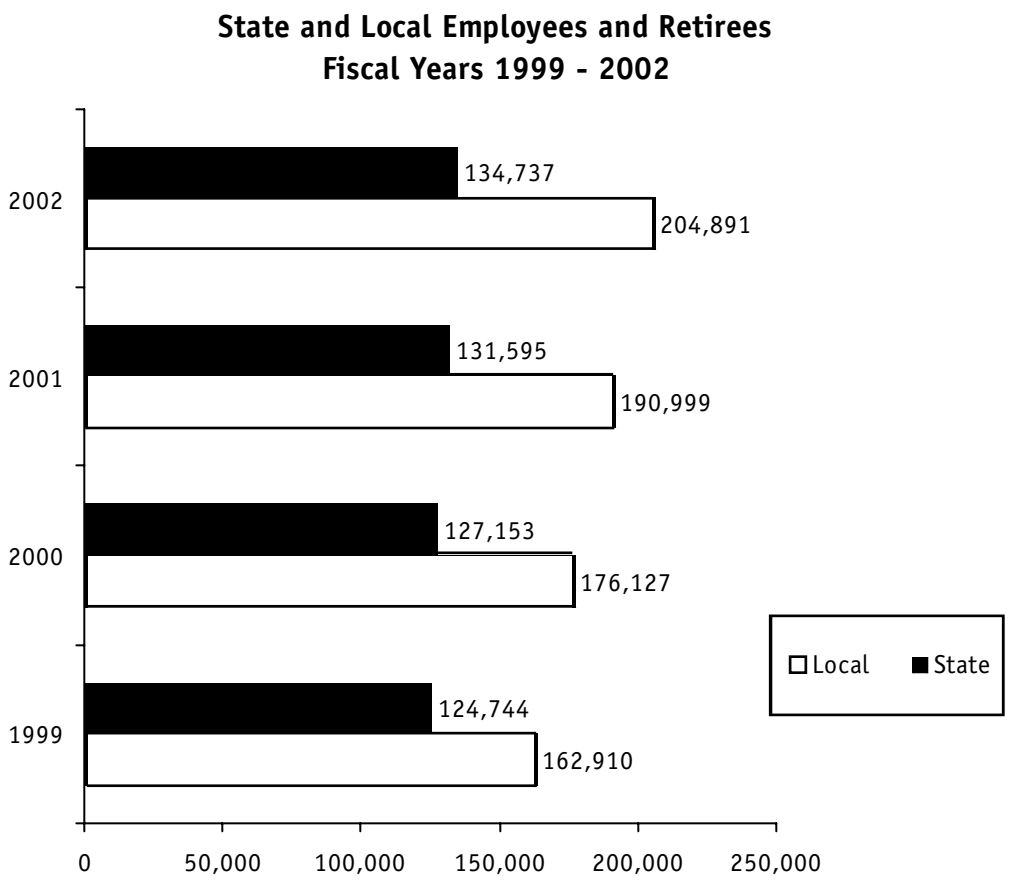
The law also amends the "Health Care Quality Act," N.J.S.A.26:2S-1 et seq., to require carriers which offer a managed care plan to disclose to subscribers, at the time of enrollment and annually thereafter, the carrier's preauthorization and review requirements of the health benefits plan regarding the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

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

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

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

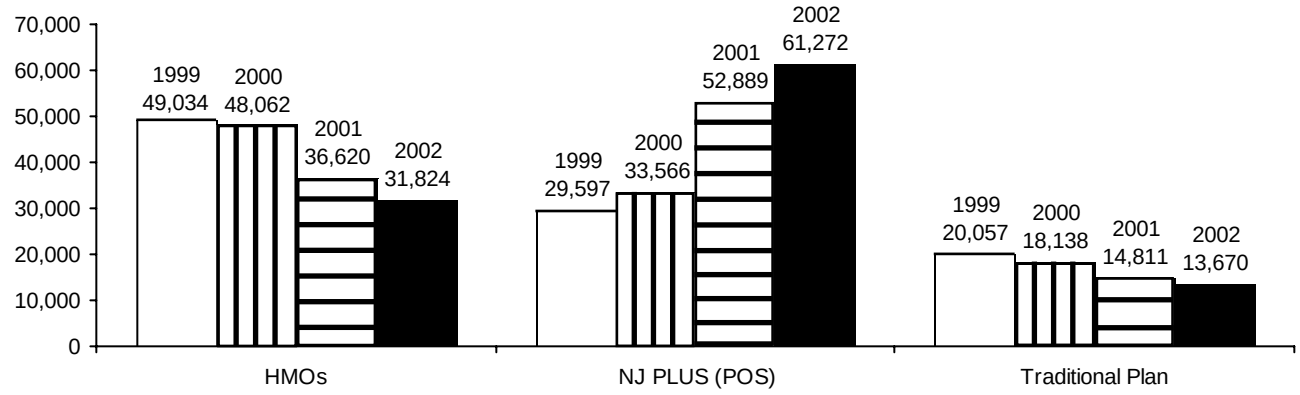
SHBP Membership



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

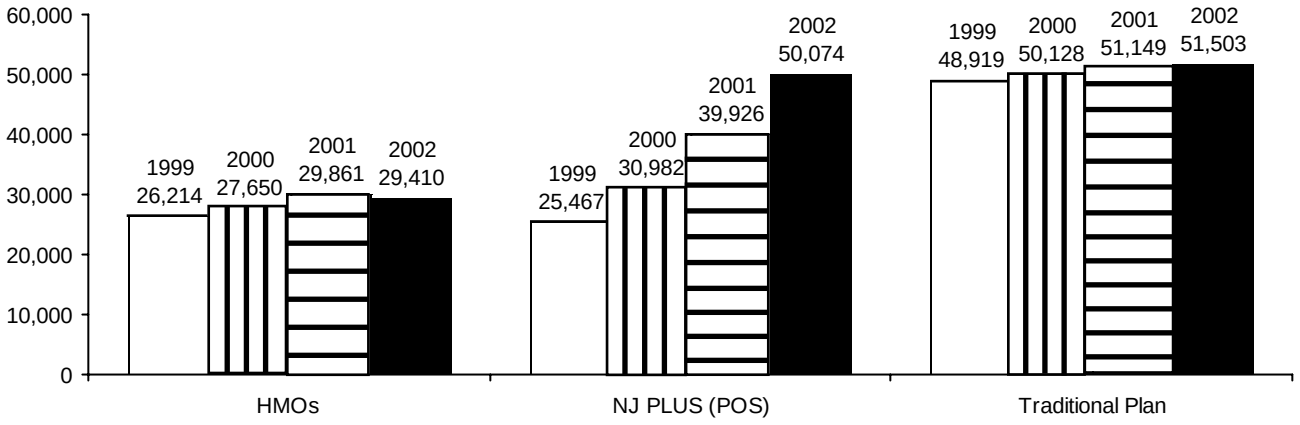
SHBP Membership

State Employees
Active Employees Plan Participation
Fiscal Years 1999 - 2002



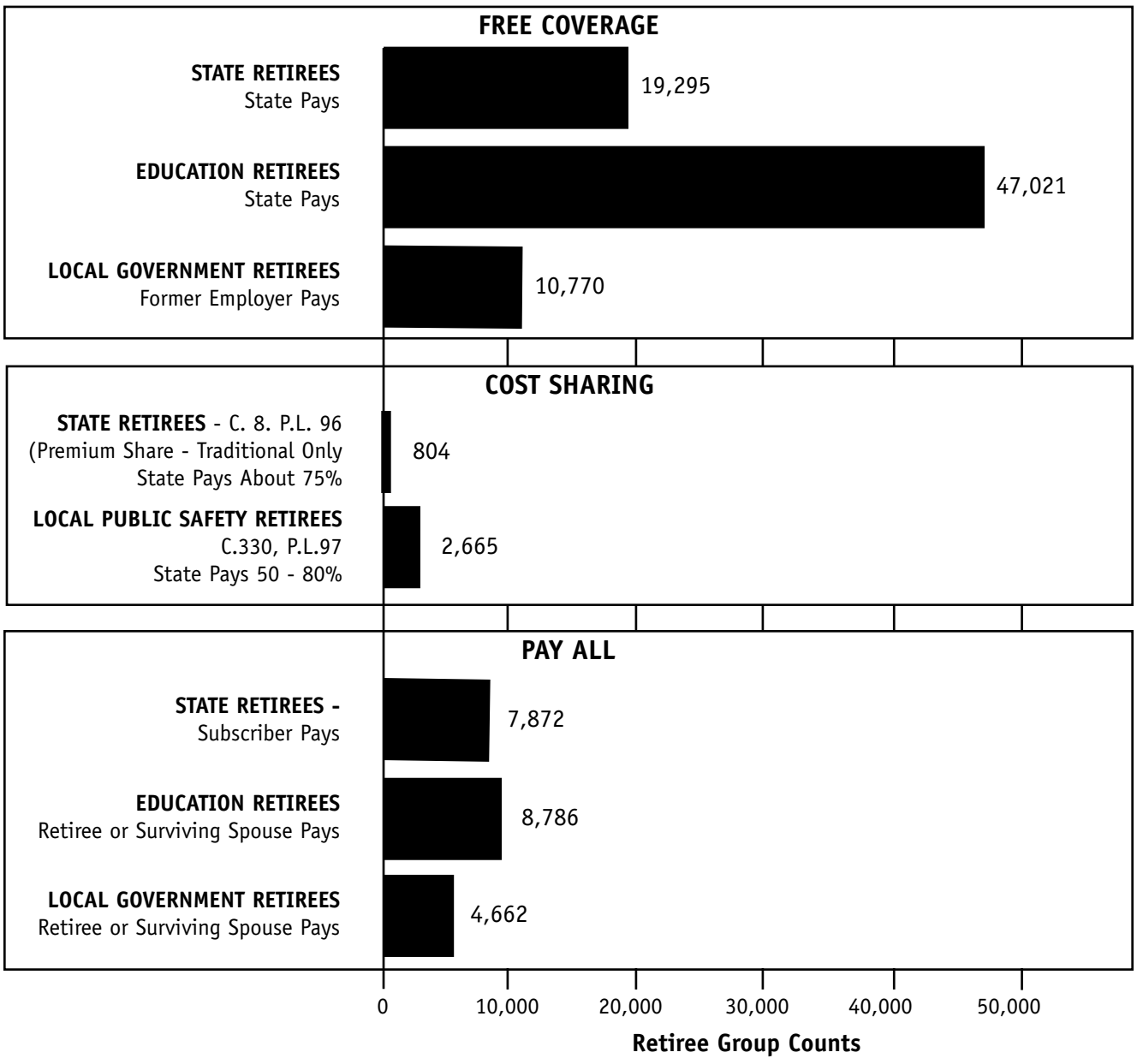
Data as of the fiscal year ended June 30th.

Local Employers
Active Employees Plan Participation
Fiscal Years 1999 - 2002



Data as of the fiscal year ended June 30th.

SHBP Retirees - Who pays for Health Benefits Coverage?



Data as of the fiscal year ended June 30th.

SHBP Enrollment — State Employer Group

As of June 30, 2002

EMPLOYEES

PLAN NAME	EMPLOYEES	AS A % OF EMPLOYEE ENROLLMENT	DEPENDENTS OF EMPLOYEES	EMPLOYEES AND DEPENDENTS
NJ PLUS	61,272	57.39%	89,019	150,291
Traditional	13,670	12.80%	14,023	27,693
Aetna, Inc.	22,918	21.47%	38,323	61,241
Cigna	2,647	2.48%	3,952	6,599
Oxford	2,235	2.10%	3,638	5,873
Amerihealth	1,605	1.50%	2,487	4,092
Healthnet	2,204	2.06%	3,527	5,731
University	215	0.20%	270	485
TOTAL	**106,766**	**100.00%**	**155,239**	**262,005**

RETIREES

PLAN NAME	RETIREES	AS A % OF RETIREE ENROLLMENT	DEPENDENTS OF RETIREES	RETIREES AND DEPENDENTS
NJ PLUS	5,235	18.72%	3,748	8,983
Traditional	18,458	65.99%	10,174	28,632
Aetna, Inc.	3,166	11.32%	2,366	5,532
Cigna	378	1.35%	321	699
Oxford	197	0.70%	124	321
Amerihealth	208	0.74%	163	371
Healthnet	273	0.98%	194	467
University	56	0.20%	27	83
TOTAL	**27,971**	**100.00%**	**17,117**	**45,088**

BOTH EMPLOYEES AND RETIREES

PLAN NAME	EMPLOYEES AND RETIREES	DEPENDENTS OF EMPLOYEES AND RETIREES	TOTAL	AS A % OF ALL STATE ENROLLMENT (TOTAL LIVES)
NJ PLUS	66,507	92,767	159,274	51.87%
Traditional	32,128	24,197	56,325	18.34%
Aetna, Inc.	26,084	40,689	66,773	21.74%
Cigna	3,025	4,273	7,298	2.38%
Oxford	2,432	3,762	6,194	2.02%
Amerihealth	1,813	2,650	4,463	1.45%
Healthnet	2,477	3,721	6,198	2.02%
University	271	297	568	0.18%
TOTAL	**134,737**	**172,356**	**307,093**	**100.00%**

SHBP Enrollment — Local Employer Group — Education

As of June 30, 2002

EMPLOYEES

PLAN NAME	EMPLOYEES	AS A % OF EMPLOYEE ENROLLMENT	DEPENDENTS OF EMPLOYEES	EMPLOYEES AND DEPENDENTS
NJ PLUS	30,926	36.81%	47,939	78,865
Traditional	35,998	42.85%	48,113	84,111
Aetna, Inc.	10,552	12.56%	16,982	27,534
Cigna	1,787	2.13%	2,950	4,737
Oxford	2,039	2.43%	3,364	5,403
Amerihealth	1,089	1.30%	1,808	2,897
Healthnet	1,562	1.86%	2,588	4,150
University	61	0.07%	102	163
TOTAL	**84,014**	**100.00%**	**123,846**	**207,860**

RETIREES

PLAN NAME	RETIREES	AS A % OF RETIREE ENROLLMENT	DEPENDENTS OF RETIREES	RETIREES AND DEPENDENTS
NJ PLUS	6,255	11.21%	4,788	11,043
Traditional	46,199	82.78%	27,524	73,723
Aetna, Inc.	2,403	4.30%	1,732	4,135
Cigna	418	0.75%	336	754
Oxford	118	0.21%	69	187
Amerihealth	251	0.45%	225	476
Healthnet	143	0.26%	99	242
University	20	0.04%	10	30
TOTAL	**55,807**	**100.00%**	**34,783**	**90,590**

BOTH EMPLOYEES AND RETIREES

PLAN NAME	EMPLOYEES AND RETIREES	DEPENDENTS OF EMPLOYEES AND RETIREES	TOTAL	AS A % OF ALL ENROLLMENT (TOTAL LIVES)
NJ PLUS	37,181	52,727	89,908	30.13%
Traditional	82,197	75,637	157,834	52.88%
Aetna, Inc.	12,955	18,714	31,669	10.61%
Cigna	2,205	3,286	5,491	1.84%
Oxford	2,157	3,433	5,590	1.87%
Amerihealth	1,340	2,033	3,373	1.13%
Healthnet	1,705	2,687	4,392	1.47%
University	81	112	193	0.07%
TOTAL	**139,821**	**158,629**	**298,450**	**100.00%**

SHBP Enrollment — Local Employer Group — Government Employers

As of June 30, 2002

EMPLOYEES

PLAN NAME	EMPLOYEES	AS A % OF EMPLOYEE ENROLLMENT	DEPENDENTS OF EMPLOYEES	EMPLOYEES AND DEPENDENTS
NJ PLUS	19,148	40.76%	32,018	51,166
Traditional	15,505	33.01%	22,164	37,669
Aetna, Inc.	7,355	15.66%	12,659	20,014
Cigna	1,451	3.09%	2,835	4,286
Oxford	1,016	2.16%	2,076	3,092
Amerihealth	654	1.39%	1,068	1,722
Healthnet	1,818	3.87%	3,353	5,171
University	26	0.06%	46	72
TOTAL	**46,973**	**100.00%**	**76,219**	**123,192**

RETIREES

PLAN NAME	RETIREES	AS A % OF RETIREE ENROLLMENT	DEPENDENTS OF RETIREES	RETIREES AND DEPENDENTS
NJ PLUS	2,780	15.36%	2,522	5,302
Traditional	13,466	74.41%	8,794	22,260
Aetna, Inc.	1,125	6.21%	1,147	2,272
Cigna	275	1.52%	334	609
Oxford	143	0.79%	119	262
Healthnet	103	0.57%	105	208
Physicians	182	1.01%	206	388
University	23	0.13%	17	40
TOTAL	**18,097**	**100.00%**	**13,244**	**31,341**

BOTH EMPLOYEES AND RETIREES

PLAN NAME	EMPLOYEES AND RETIREES	DEPENDENTS OF EMPLOYEES AND RETIREES	TOTAL	AS A % OF ALL ENROLLMENT (TOTAL LIVES)
NJ PLUS	21,928	34,540	56,468	36.54%
Traditional	28,971	30,958	59,929	38.78%
Aetna, Inc.	8,480	13,806	22,286	14.42%
Cigna	1,726	3,169	4,895	3.17%
Oxford	1,159	2,195	3,354	2.17%
Amerihealth	757	1,173	1,930	1.25%
Healthnet	2,000	3,559	5,559	3.60%
University	49	63	112	0.07%
TOTAL	**65,070**	**89,463**	**154,533**	**100.00%**

SHBP Enrollment by State and Local Employer Groups

As of June 30, 2002

EMPLOYEE

PLAN NAME	EMPLOYEES	AS A % OF EMPLOYEE ENROLLMENT	DEPENDENTS OF EMPLOYEES	EMPLOYEES AND DEPENDENTS
NJ PLUS	111,346	46.83%	168,976	280,322
Traditional	65,173	27.41%	84,300	149,473
Aetna, Inc.	40,825	17.17%	67,964	108,789
Cigna	5,885	2.48%	9,737	15,622
Oxford	5,290	2.22%	9,078	14,368
Amerihealth	3,348	1.41%	5,363	8,711
Healthnet	5,584	2.35%	9,468	15,052
University	302	0.13%	418	720
TOTAL	**237,753**	**100.00%**	**355,304**	**593,057**

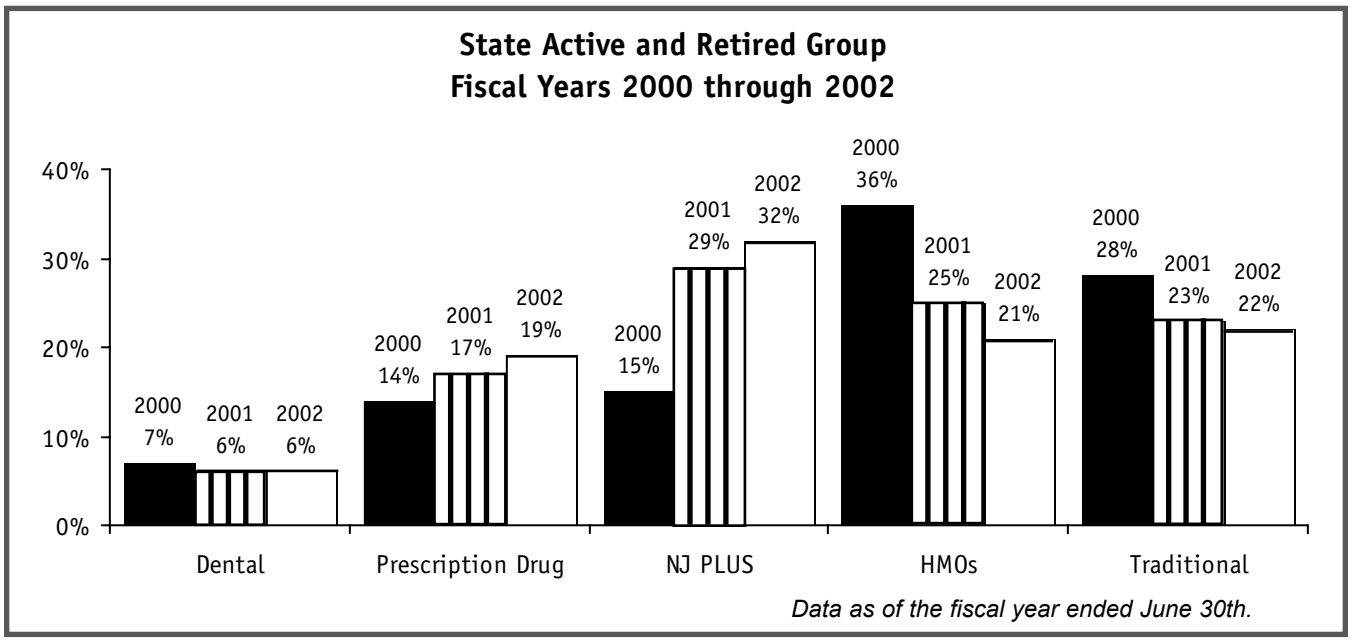
RETIREES

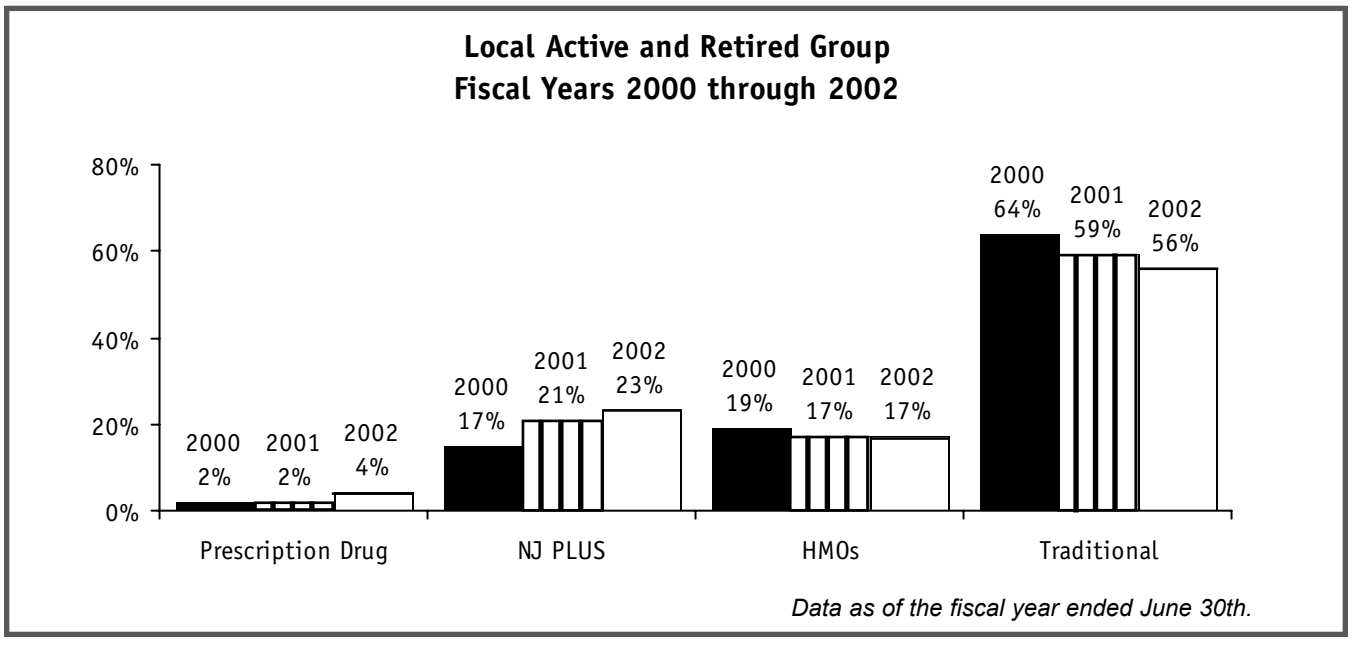
PLAN NAME	RETIREES	AS A % OF RETIREE ENROLLMENT	DEPENDENTS OF RETIREES	RETIREES AND DEPENDENTS
NJ PLUS	14,270	14.00%	11,058	25,328
Traditional	78,123	76.69%	46,492	124,615
Aetna, Inc.	6,694	6.57%	5,245	11,939
Cigna	1,071	1.05%	991	2,062
Oxford	458	0.45%	312	770
Amerihealth	562	0.55%	493	1,055
Healthnet	598	0.59%	499	1,097
University	99	0.10%	54	153
TOTAL	**101,875**	**100.00%**	**65,144**	**167,019**

BOTH EMPLOYEES AND RETIREES

PLAN NAME	EMPLOYEES AND RETIREES	DEPENDENTS OF EMPLOYEES AND RETIREES	TOTAL	AS A % OF ALL SHBP ENROLLMENT (TOTAL LIVES)
NJ PLUS	125,616	180,034	305,650	40.21%
Traditional	143,296	130,792	274,088	36.06%
Aetna, Inc.	47,519	73,209	120,728	15.89%
Cigna	6,956	10,728	17,684	2.33%
Oxford	5,748	9,390	15,138	1.99%
Amerihealth	3,910	5,856	9,766	1.29%
Healthnet	6,182	9,967	16,149	2.12%
University	401	472	873	0.11%
TOTAL	**339,628**	**420,448**	**760,076**	**100.00%**

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





SHBP Local Participation 1996 - 2002

	COUNTIES	SCHOOL DISTRICTS	MUNICI-PALITIES	OTHERS*	CHARTER SCHOOLS**	SUB TOTAL	SUB GROUPS***	TOTAL
JUL 1996	4	256	243	248		751	19	**770**
JAN 1997	3	206	229	247		685	17	**702**
JUL 1997	3	218	224	250		695	21	**716**
JAN 1998	3	221	225	250	7	706	21	**727**
JUL 1998	3	236	228	250	9	726	20	**746**
JAN 1999	4	245	227	250	9	735	22	**757**
JUL 1999	4	280	230	253	9	776	23	**799**
JAN 2000	4	278	236	257	20	795	25	**820**
JUL 2000	4	293	246	254	22	819	29	**848**
JAN 2001	4	295	254	267	23	843	35	**878**
JUL 2001	4	307	267	268	23	869	37	**906**
JAN 2002	4	310	279	268	24	885	38	**923**
JUL 2002	5	312	293	274	23	907	37	**944**

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

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

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

SHBP Participation by Dental Plans as of June 30, 2002

PLAN NAME	ESTIMATED STATE EMPLOYEE CONTRACTS	AS A % OF ALL EMPLOYEES	AS A % OF ALL DENTAL CONTRACTS
Dental Expense Plan	49,847	47%	53%
DENTAL PROVIDER ORGANIZATIONS			
Unity Dental	5,777	5%	6%
International HealthCare	5,005	5%	5%
Atlantic Southern	7,140	7%	8%
Fortis	3,390	3%	4%
Flagship Health	2,010	2%	2%
Community Dental	1,635	2%	1%
Horizon Healthcare Dental (Managed Den)	4,517	4%	5%
Aetna DMO	9,255	9%	10%
Group Dental	397	0%	0%
Cigna Dental Health	5,671	5%	6%
Subtotals	**94,644**	**89%**	**100%**
Employees that did not elect coverage	12,122	11%	NA
Totals	**106,766**	**100%**	**100%**

KPMG LLP
Princeton Pike Corporate Center
P.O. Box 7348
Princeton, NJ 08543-7348

Independent Auditors' Report

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

We have audited the financial statements of the State of New Jersey Health Benefits Program Funds, Dental Expense Program Fund, and Prescription Drug Program Funds (the Funds) as of and for the year ended June 30, 2002 as listed in the accompanying index. These financial statements are the responsibility of the Funds' management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

As discussed in Note 1, the financial statements of the Funds are intended to present the financial position, and the changes in financial position and cash flows, where applicable, of only that portion of the governmental and proprietary funds, of the State that is attributable to the transactions of the Division of Pensions and Benefits. They do not purport to, and do not, present fairly the financial position of the State of New Jersey as of June 30, 2002, and the changes in its financial position and its cash flows, where applicable, for the year then ended in conformity with accounting principles generally accepted in the United States of America.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the State of New Jersey Health Benefits Program Funds, Dental Expense Program Fund, and Prescription Drug Program Funds as of June 30, 2002, and the results of their operations and cash flows for the year then ended in conformity with accounting principles generally accepted in the United States of America.

As discussed in Note 2, the Funds adopted Governmental Accounting Standards Board (GASB) Statement No. 34, *Basic Financial Statements - and Management's Discussion and Analysis - for State and Local Governments*, as amended by No. 37, *Basic Financial Statements - and Management's Discussion and Analysis - for State and Local Governments: Omnibus,* as of July 1, 2000.

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

KPMG LLP

September 6, 2002

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

June 30, 2002

INDEX

MANAGEMENT'S DISCUSSION AND ANALYSIS
Health Benefits Program Fund - State and Local
Dental Expense Program Fund
Prescription Drug Program Fund - State and Local

June 30, 2002 and 2001

Our discussion and analysis of the financial performance of the Health Benefits Program Fund - State and Local, Dental Expense Program Fund and Prescription Drug Program Fund - State and Local (the Funds) provides an overview of the Funds' financial activities for the fiscal year ended June 30, 2002. Please read it in conjunction with the basic financial statements and financial statement footnotes which follow this discussion.

FINANCIAL HIGHLIGHTS

Governmental Funds:

- For Health Benefits Program Fund-State, fund balances decreased by $54,220,616 as a result of operations from $54,229,706 to $9,090. For Prescription Drug Program Fund-State, fund balances increased by $1,251,672 from $4,881,803 to $6,133,475. For Dental Expense Program Fund, fund balances increased by $8,205,609 from $12,230,490 to $20,436,099.
- For Health Benefits Program Fund-State, Prescription Drug Program Fund-State and the Dental Expense Program Fund, revenues recognized during the year were $656,201,354, $163,474,960, and $59,288,315, respectively.
- For Health Benefits Program Fund-State, Prescription Drug Program Fund-State and the Dental Expense Program Fund, expenditures incurred during the year were $713,451,970, $159,193,288, and $51,082,706, respectively.

Proprietary Funds:

- For Health Benefits Program Fund-Local, net assets decreased by $57,523,685 as a result of operations from ($2,176,331) to ($59,700,016). For Prescription Drug Program Fund-Local, net assets increased by $3,431,817 from $1,773,031 to $5,204,848.
- For the Health Benefits Program Fund-Local and the Prescription Drug Program Fund-Local, revenues recognized during the year were $1,120,383,358 and $43,091,619, respectively.
- For Health Benefits Program Fund-Local and the Prescription Drug Program Fund-Local, expenses incurred during the year were $1,177,907,043 and $39,659,802, respectively.

THE BALANCE SHEET / STATEMENT OF NET ASSETS (DEFICIT), THE STATEMENT OF REVENUES, EXPENDITURES / EXPENSES, AND CHANGES IN FUND BALANCES / NET ASSETS (DEFICIT), AND THE STATEMENT OF CASH FLOWS

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

The annual report for governmental and proprietary funds consists of the following:

Governmental Funds:

Balance Sheet
Statement of Revenues, Expenditures, and Changes in Fund Balances

Proprietary Funds:

Statement of Net Assets (Deficit)
Statement of Revenues, Expenses, and Changes in Net Assets (Deficit)
Statement of Cash Flows

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

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

FINANCIAL ANALYSIS

BALANCE SHEET / STATEMENT OF NET ASSETS (DEFICIT)

Governmental Funds:

The Funds' assets mainly consist of cash, investments, contributions due from members, participating employers, and former members who are covered under the rules of COBRA, and contributions due from the Public Employees' Retirement System and the Teachers' Pension and Annuity Fund to provide funding for post-retirement medical benefits. Between fiscal year 2001 and 2002, total assets decreased by $44,847,878 from $117,402,504 to $72,554,626. The reduction in total assets is mainly due to higher than anticipated claim charges for the health plans. Medical costs incurred by the plans were higher than forecasted when the rates in effect during the fiscal period were established.

Liabilities mainly consist of outstanding claim payments. Total liabilities decreased by $84,543 or 0.2% since the prior year from $46,060,505 to $45,975,962.

Fund balances decreased by $44,763,335 or 62.7% from $71,341,999 to $26,578,664 mainly due to the high claim charges incurred by the health plans.

Proprietary Funds:

The Funds' assets mainly consist of cash, investments, and contributions due from members, participating employers, and former members who are covered under the rules of COBRA. Between fiscal year 2001 and 2002, total assets decreased by $44,080,265 from $187,726,653 to $143,646,388. The reduction in total assets is mainly due to higher than anticipated claim charges for the health plans. Medical costs incurred by the plans were higher than forecasted when the rates for the fiscal period were established.

Liabilities mainly consist of unpaid claims and incurred but not reported claims. Total liabilities increased by $10,011,605 or 5.3% since the prior year from $188,129,951 to $198,141,556.

Net assets decreased by $54,091,870 from ($403,298) to ($54,495,168) mainly due to the high claim charges incurred by the health plans.

STATEMENT OF REVENUES, EXPENDITURES/EXPENSES, AND CHANGES IN FUND BALANCES/NET ASSETS (DEFICIT)

REVENUES - ADDITIONS TO FUND BALANCES / NET ASSETS

Governmental Funds:

	2002	2001	Increase(Decrease)
Member Contributions	$ 92,615,336	$ 87,163,245	$ 5,452,091
Employer Contributions	783,945,829	724,707,205	59,238,624
Investment & Other	2,403,464	6,590,826	(4,187,362)
Totals	$ 878,964,629	$ 818,461,276	$ 60,503,353

Proprietary Funds:

	2002	2001	Increase(Decrease)
Member Contributions	$ 62,065,953	$ 54,016,936	$ 8,049,017
Employer Contributions	1,098,924,109	918,328,713	180,595,396
Investment & Other	2,484,915	8,639,480	(6,154,565)
Totals	$ 1,163,474,977	$ 980,985,129	$ 182,489,848

Revenues primarily consist of member and employer contributions and earnings from investment activities. For the Governmental Funds, revenues increased by 7.4% from $818,461,276 to $878,964,629. For the Proprietary Funds, total revenues increased by 18.6% from $980,985,129 to $1,163,474,977. The increase in revenues is attributable to an increase in the premium rates for the health and prescription drug plans. Member contributions also increased by 6.3% for the Governmental Funds and 14.9% for the Proprietary Funds due to the rate increases. Investment revenues are down due to a reduction in Cash Management Fund earnings.

EXPENDITURES / EXPENSES - DEDUCTIONS FROM FUND BALANCES / NET ASSETS

Governmental Funds:

	2002	2001	Increase(Decrease)
Benefits	$ 921,381,161	$ 755,792,348	$ 165,588,813
Administrative Expenses	2,346,803	4,073,026	(1,726,223)
Totals	$ 923,727,964	$ 759,865,374	$ 163,862,590

Proprietary Funds:

	2002	2001	Increase(Decrease)
Benefits	$ 1,212,090,971	$ 1,029,378,583	$ 182,712,388
Administrative Expenses	5,475,874	4,718,163	757,711
Totals	$ 1,217,566,845	$ 1,034,096,746	$ 183,470,099

Expenditures or expenses consist of benefit charges and administrative expenses. During the year, expenditures

increased by $163,862,590 or 21.6% for the Governmental Funds and expenses increased by $183,470,099 or 17.7% for the Proprietary Funds primarily due to rising health and prescription drug costs. Administrative expenses decreased due to a reclassification of service charges to regular benefit payments.

OVERALL FINANCIAL CONDITION OF THE FUNDS

For the State Health Benefits Program Fund - State and the State Health Benefits Program Fund - Local, contributions received by the Funds to pay the premiums for covered members have not kept pace with the rising health costs and, as a result, most reserves have been fully depleted. To begin to restore the fund balances to prudent levels, double-digit rate increases were established for all health plans for calendar year 2003. Management anticipates that through future rate action and other initiatives, the Funds will become financially stronger.

The Prescription Drug and Dental Program Funds received sufficient contributions to meet this year's benefit obligations. In addition, fund balances have increased since last year which indicates that the Funds are becoming financially stronger. Through future rate action and other initiatives, management anticipates that the financial condition of these benefit programs will continue to improve.

CONTACTING SYSTEM FINANCIAL MANAGEMENT

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

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

Balance Sheet/Statement of Net Assets (Deficit)

Year ended June 30, 2002

	GOVERNMENTAL FUNDS			PROPRIETARY FUNDS		
	HEALTH BENEFITS PROGRAM FUND STATE	DENTAL EXPENSE PROGRAM FUND	PRESCRIPTION DRUG PROGRAM FUND STATE	HEALTH BENEFITS PROGRAM FUND LOCAL	PRESCRIPTION DRUG PROGRAM FUND LOCAL	LONG TERM DEBT ACCOUNT GROUP
Assets:						
Cash and cash equivalents	$ 363,462	—	—	4,027,294	100,551	—
Investments, at fair value:						
U.S. Treasury notes	—	—	—	—	—	—
Cash Management Fund	22,678,504	17,307,200	21,182,246	56,073,207	3,882,133	—
Total investments	22,678,504	17,307,200	21,182,246	56,073,207	3,882,133	—
Receivables:						
Other	856,001	411,875	—	72,569,120	4,532,830	—
Due from other funds	5,301,220	4,454,118	—	2,461,253	—	—
Total receivables	6,157,221	4,865,993	—	75,030,373	4,532,830	—
Other debits:						
Amount to be provided	—	—	—	—	—	95,780,000
Total assets	$ 29,199,187	22,173,193	21,182,246	135,130,874	8,515,514	95,780,000
Liabilities:						
Accounts payable and accrued expenses	$ 29,015,429	1,654,903	11,991,233	20,963,330	—	—
Deferred revenue	—	—	3,740	—	21,217	—
Incurred but not reported claims	—	—	—	173,460,000	3,250,000	95,780,000
Due to other funds	174,668	82,191	3,053,798	407,560	39,449	—
Total liabilities	29,190,097	1,737,094	15,048,771	194,830,890	3,310,666	95,780,000
Fund Balances/Net Assets:						
Net Assets	—	—	—	(59,700,016)	5,204,848	—
Fund Balances	9,090	20,436,099	6,133,475	—	—	—
Total liabilities and fund balances/net assets	$ 29,199,187	22,173,193	21,182,246	135,130,874	8,515,514	95,780,000

See accompanying notes to financial statements.

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

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

Year ended June 30, 2002

	HEALTH BENEFITS PROGRAM FUND STATE	DENTAL EXPENSE PROGRAM FUND	PRESCRIPTION DRUG PROGRAM FUND STATE
Revenues:			
Contributions:			
Members	$ 61,646,089	30,008,187	961,060
Employers	593,436,023	28,413,806	162,096,000
Total contributions	655,082,112	58,421,993	163,057,060
Investment income:			
Net appreciation (depreciation) in fair value of investments	50,098	412,378	53,876
Interest	1,069,144	453,944	364,024
Total investment income	1,119,242	866,322	417,900
Total revenues	656,201,354	59,288,315	163,474,960
Expenditures:			
Benefits	711,105,167	51,082,706	159,193,288
Administrative expense	2,346,803	—	—
Total expenditures	713,451,970	51,082,706	159,193,288
Excess (deficiency) of revenues over (under) expenditures	(57,250,616)	8,205,609	4,281,672
Other Financing Sources (Uses):			
Transfers in	3,030,000	—	—
Transfers out	—	—	(3,030,000)
Total other financing sources and uses	3,030,000	—	(3,030,000)
Net change in fund balances	(54,220,616)	8,205,609	1,251,672
Fund Balances:			
Beginning of year	54,229,706	12,230,490	4,881,803
End of year	$ 9,090	20,436,099	6,133,475

See accompanying notes to financial statements.

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

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

Year ended June 30, 2002

	HEALTH BENEFITS PROGRAM FUND LOCAL	PRESCRIPTION DRUG PROGRAM FUND LOCAL
Operating Revenues:		
Contributions:		
Members	$ 61,789,457	276,496
Employers	1,056,207,344	42,716,765
Total operating revenues	1,117,996,801	42,993,261
Operating Expenses:		
Benefits	1,172,431,169	39,659,802
Administrative expense	5,475,874	—
Total operating expenses	1,177,907,043	39,659,802
Operating income (loss)	(59,910,242)	3,333,459
Non-operating Revenue:		
Investment income:		
Net appreciation (depreciation) in fair value of investments	85,792	8,949
Interest	2,300,765	89,409
Total non-operating revenue	2,386,557	98,358
Change in net assets (deficit)	(57,523,685)	3,431,817
Net Assets (Deficit):		
Beginning of year	(2,176,331)	1,773,031
End of year	$ (59,700,016)	5,204,848

See accompanying notes to financial statements.

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

Statement of Cash Flows
Proprietary Funds

Year ended June 30, 2002

	HEALTH BENEFITS PROGRAM FUND LOCAL	PRESCRIPTION DRUG PROGRAM FUND LOCAL
Cash flows from operating activities:		
Receipts - Employer Contributions	$ 1,039,773,880	40,284,530
Receipts - Member Contributions	61,630,499	276,496
Benefit payments	(1,113,106,737)	(38,594,151)
Premium payments	(50,427,242)	—
Administrative expense	(5,427,110)	—
Net cash provided by operating activities	(67,556,710)	1,966,875
Cash flows from investing activities:		
Interest and dividends	2,300,765	89,409
Sale/purchase of investments	67,436,722	(1,964,682)
Net appreciation of fair market value	85,792	8,949
Net cash provided by investing activities	69,823,279	(1,866,324)
Increase/decrease in cash equivalents	2,266,569	100,551
Cash and cash equivalents beginning of year	1,760,725	—
Cash and cash equivalents end of year	$ 4,027,294	100,551
Reconciliation of operating income to net cash provided (used) by operating activities		
Operating Income (gain/loss)	$ (59,910,242)	3,333,459
Adjustments to reconcile operating loss to net cash used by operating activities:		
Changes in assets and liabilities:		
(Increase)/decrease in accounts receivable	(16,552,973)	(2,432,235)
(Increase)/decrease in interfund receivable	(39,449)	—
Increase/(decrease) in accounts payable	9,770,812	1,026,202
Increase/(decrease) in service charges payable	(1,363,893)	—
Increase/(decrease) in due to other funds	539,035	39,449
Total adjustments	(7,646,468)	(1,366,584)
Net cash (used in) provided by operating activities	$ (67,556,710)	1,966,875

See accompanying notes to financial statements.

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

Notes to Financial Statements

June 30, 2002

(1) DESCRIPTION OF THE FUNDS

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

Governmental funds:

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

Proprietary funds:

State Health Benefits Program Fund (SHBP) - Local
Prescription Drug Program Fund (PDPF) - Local

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

Reporting entity:

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

Fund accounting:

The accounts of the Division are maintained in accordance with the principles of fund accounting to ensure observance of limitations and restrictions on the resources available. The principles of fund accounting require that the resources be classified for accounting and reporting purposes into funds in accordance with activities or objectives specified for the resources. Each fund is a separate accounting entity with a self-balancing set of accounts. An account group, on the other hand, is a financial reporting device designed to provide accountability for certain assets and liabilities that are not recorded in the funds because they do not directly affect net expendable available financial resources. Funds are classified into three categories: governmental, proprietary and fiduciary. Each category, in turn, is divided into separate "fund types."

(1) DESCRIPTION OF THE FUNDS, Continued

Governmental funds:

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

Proprietary funds:

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

Long-term debt account group:

General Long-Term Debt Account Group: Long-term liabilities expected to be financed from governmental funds are accounted for in the General Long-Term Debt Account Group, not in the governmental funds. This includes the non-current portion for the liability for incurred but not reported claims of the Governmental Funds.

(2) SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Measurement Focus and Basis of Accounting:

The accounting and financial reporting treatment applied to a fund is determined by its measurement focus. All funds, except for the governmental funds, are accounted for using an economic resources measurement focus. Funds that focus on total economic resources employ the accrual basis of accounting, which recognizes increases and decreases in economic resources as soon as the underlying event or transaction occurs.

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

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

Incurred but not reported (IBNR) claims are recognized as expenses to the extent funds are available to meet those claims. The balance is reported in the long-term debt account group.

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

New Accounting Standards Adopted:

Effective July 1, 2000, the Division adopted two new statements of financial accounting standards issued by the Governmental Accounting Standards Board (GASB):

(2) SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES, Continued

Statement No. 34 *Basic Financial Statements - and Management's Discussion and Analysis - for State and Local Governments*

Statement No. 37 *Basic Financial Statements - and Management's Discussion and Analysis - for State and Local Governments: Omnibus*

Statement No. 34 (as amended by Statement No. 37) requires as required supplementary information Management's Discussion and Analysis which includes an analytical overview of the Funds' financial activities.

Capital Assets:

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

Investment Valuation:

Investments, including short-term investments (State of New Jersey Cash Management Funds) are reported at fair value. Securities traded on a national or international exchange are valued at the last reported sales price at current exchange rates. Mortgages are valued on the basis of future principal and interest payments, and are discounted at prevailing interest rates for similar instruments. Investments that do not have an established market are reported at estimated fair values.

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

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

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

GASB Statement No. 3 requires disclosure of the level of custodial risk assumed by the Funds. Category 1 includes investments that are insured or registered or for which the securities are held by the Funds or its agent in the Funds' name. As of June 30, 2001, all investments held by the Funds (other than mortgages and the State of New Jersey Cash Management Funds which are not categorized) are classified as Category 1.

Federal securities are maintained at Federal Reserve Banks in Philadelphia and New York through the custodian banks in trust for the Funds. A significant portion of corporate equity and debt securities are maintained by the Depository Trust Company (DTC) through the custodian banks in trust for the Funds. The cus-

(2) SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES, Continued

todian banks as agents for the Funds maintain internal accounting records identifying the securities maintained by the Federal Reserve Banks and the DTC as securities owned by or pledged to the Funds.

Securities not maintained by the Federal Reserve Banks or DTC are in the name of a designated nominee representing the securities of the Funds, which establishes the Funds' unconditional right to the securities.

Membership and Contributing Employers:

Membership in the funds administered by the Division consisted of the following as of June 30, 2002:

	STATE	LOCAL	TOTAL
Health Benefits Program Fund*	135,011	204,705	339,716
Prescription Drug Program Fund	106,793	26,631	133,424
Dental Expense Program Fund	94,836	—	94,836

*active and retired participants

Administrative Expenses:

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

Cash and Cash Equivalents:

GASB Statement No. 3 also requires that deposits held in financial institutions be categorized to indicate the level of risk assumed by the entity. Category 1 consists of deposits that are insured or collateralized with securities held by the entity or by its agent in the entity's name. Category 2 consists of deposits collateralized with securities held by the pledging financial institutions trust department or agent in the entity's name. Category 3 consists of deposits which are uninsured and uncollateralized.

Based upon aggregate collateral levels maintained for all State bank accounts as a whole, substantially all cash balances maintained in financial institutions as of June 30, 2002, which includes funding for the July 1, 2002 retirement payroll, are designated category 3.

The categorization of cash and cash equivalents for all State funds can be found in the notes to the general purpose financial statements of the State of New Jersey.

(3) Contributions

Contribution Requirements - SHBP- State and Local

Contributions to pay for the health premiums of participating employees in the State Health Benefits Program (SHBP) are collected from the State of New Jersey, participating local employers, active members, retired members, the Public Employees' Retirement System (PERS), and the Teachers' Pension and Annuity Fund (TPAF). The State of New Jersey provides contributions for State employees through State appropriations. These appropriations are generally distributed to the SHBP on a monthly basis. Local employer pay-

(3) CONTRIBUTIONS, Continued

ments, active and retired member contributions, and payments from the PERS and TPAF are generally received on a monthly basis. Certain State employees share in the cost of their premiums, as provided by Chapter 8, P.L. 1996.

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

Contribution Requirements - PDPF- State and Local

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

Contribution Requirements - DEPF

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

(4) VESTING AND BENEFITS

Vesting and Benefit Provisions - SHBP - State and Local

The Program provides medical coverage to qualified active and retired participants. Under Chapter 136, P.L. 1977, the State of New Jersey pays for the health insurance coverage of all enrolled retired State employees (regardless of age) whose pensions are based upon 25 years or more of credited service or a disability retirement regardless of years of service. The State of New Jersey also provides free coverage to members of the Public Employees' Retirement System, Teachers' Pension and Annuity Fund, and the Alternate Benefit Program who retire from a board of education or county college with 25 years of service or on a disability retirement. Partially funded benefits are also provided to local police officers and firefighters who retire

(4) VESTING AND BENEFITS, Continued

with 25 years of service (or on disability) from an employer who does not provide coverage. Retirees who are not eligible for employer paid health coverage at retirement can continue in the program by paying the cost of the insurance for themselves and their covered dependents.

Benefit Provisions - PDPF - State and Local

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

Benefit Provisions - DEPF

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

(5) RESERVE FUNDS

The Funds maintain the following legally required reserve funds as follows:

Reserve Fund - SHBP - State ($9,090); PDPF - State ($6,133,475); and DEPF ($20,436,099)

The net assets of the SHBP - State, PDPF - State, and DEPF are available to pay claims of future periods. These reserves are maintained by the Funds to stabilize rates and to meet unexpected increase in claims. Since these funds are classified as governmental funds, IBNR claims as of June 30, 2002 are reported in the State's general long-term debt account group.

Reserve Fund - SHBP - Local (-$59,700,016); PDPF - Local ($5,204,848)

The SHBP - local has a fund deficit of $59,700,016 as of June 30, 2002. This deficit is expected to be made up by some future rate action.

The PDPF - local has net assets, which are available to pay claims of future periods and stabilize rates.

(6) UNPAID CLAIMS LIABILITIES

As discussed in Note 2, the Fund establishes a liability for both reported and unreported claims, which includes estimates of future payments of claims and related claim adjustment expenses. The following represent changes in those aggregate liabilities for the Funds during the year:

(6) UNPAID CLAIMS LIABILITIES, Continued

LOCAL	HEALTH BENEFITS PROGRAM FUND	PRESCRIPTION DRUG PROGRAM FUND
Unpaid claims at beginning of year	$ 185,526,140	$ 2,245,015
Incurred claims:		
Provision for insured events of current year	1,172,431,169	39,654,401
Payments	(1,163,533,979)	(38,649,416)
Unpaid claims at end of year	$ 194,423,330	$ 3,250,000

Schedule 1

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

Loss Development Information

June 30, 2002

HEALTH BENEFITS PROGRAM FUND - LOCAL	FISCAL YEAR ENDED JUNE 30, 2002
Premiums and investment revenue Earned	$ 1,117,996,801
Estimated losses and expenses	1,177,907,043

PRESCRIPTION DRUG PROGRAM FUND - LOCAL	FISCAL YEAR ENDED JUNE 30, 2002
Premiums and investment revenue Earned	$ 42,993,261
Estimated losses and expenses	39,659,802

See independent auditors' report.

APPENDIX A

New Jersey State Health Benefits Program

Related State Legislation

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

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

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

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

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

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

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

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

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

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

Chapter 384, P.L. 1987, although designed to bring benefits for retired teachers in line with those for state retirees, affected many other retirees also. The law permitted the Teachers' Pension and Annuity Fund

(TPAF) to pay for the State Health Benefits Program coverage of members receiving retirement allowances based upon 25 or more years of credited service or a disability retirement (regardless of years of service). In addition to paying for the cost of coverage, the pension fund reimburses eligible retirees and/or covered spouses for the cost of Part B (medical insurance) of the federal Medicare program. The TPAF began paying for coverage as of June 1, 1988. Those eligible retirees not already enrolled were given an opportunity through May 31, 1988, to enroll in the program. One of the most important features of this law is that it applies to all eligible TPAF members (except those who elected a deferred retirement - adjusted by Chapter 126, P.L. 1992), not just those who belong to the State Health Benefits Program while actively employed. Beginning June 1, 1988, a new TPAF retiree qualifying for TPAF-paid coverage was offered the opportunity to join this program.

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

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

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

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

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

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

children of members for whom an accidental death benefit was payable.

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

Chapter 126, P.L. 1992 provides that members of the Public Employees' Retirement System (PERS) and the Alternate Benefits Program (ABP) who retired from a school board of education or a county college with a benefit based upon 25 or more years of service or on a disability pension based upon fewer years of service credit and receive a retirement allowance from that system are eligible for state-paid health coverage regardless of employers' participation in the SHBP

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

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

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

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

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

Chapter 8, P.L. 1996 applies to state employees in the executive, legislative, and judicial branches of government as well as employees of the state universities and colleges and independent commissions and agencies participating in the SHBP. The law applies to local employers only with regards to provisions affecting Medicare reimbursement for active employees and the HMO coverage restrictions. Chapter 8, P.L. 1996 ends Medicare reimbursement for active employees and their spouses; prohibits dual coverage by any individual in two SHBP HMO contracts; allows active employee premium sharing resulting from labor con-

tract agreements; allows retiree premium sharing resulting from labor contract agreements; allows adjustments to retiree Medicare reimbursement resulting from labor contract agreements; authorizes the State Health Benefits Commission to establish rules governing active employee and retiree premium sharing and retiree Medicare reimbursement for employees not represented by labor unions, that is, for non-aligned employees; and grandfathers retired health coverage and retiree Medicare reimbursement for employees who retire prior to July 1, 1997, and employees who have 25 years of credited pension service before July 1, 1997, regardless of when they retire (except for deferred retirements).

Chapter 94, P.L. 1997 requires the State Health Benefits Program to provide coverage for a minimum of 72 hours of inpatient care following a modified radical mastectomy and a minimum of 48 hours of inpatient care following a simple mastectomy. The law also provides that a carrier under the program shall not require a health care provider to obtain authorization from the carrier for prescribing 72 or 48 hours, as appropriate, of inpatient care. The law shall not be construed to require a patient to receive inpatient care for 72 or 48 hours, as appropriate, if the patient in consultation with the patient's physician determines that a shorter length of stay is medically appropriate or relieve a patient or physician from any insurer notification requirements.

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

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

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

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

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

is naturally low in protein; and "medical food" is a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed under direction of a physician.

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

Chapter 48, P.L. 1999 changes the way local employers participating in the State Health Benefits Program (SHBP) can provide post-retirement health benefit coverage to its retired employees. The law makes the age and service eligibility requirements for employer payment of SHBP health benefits coverage for retired employees the same as the requirements of N.J.S.40A:10-23 currently applicable to local government employers that do not participate in SHBP. The employer may, by filing a resolution with the Division of Pensions and Benefits, assume the cost of post retirement medical coverage for employees (and their dependents) who:

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

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

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

Chapter 390, P.L. of 1999 impacts the insured managed care plans that participate in the SHBP. This law requires carriers which offer managed care plans, including health maintenance organizations and preferred provider organizations and selective contracting arrangements offered by health insurance companies in the State, to provide for the continuation of treatment by a physician, under certain circum-

stances, in the event that the physician is no longer employed by the carrier.

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

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

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

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

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

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

Health care benefits or services, as applicable, shall be provided by the health benefits plan for treatment of the specified conditions and any medically necessary treatment to the same extent as such benefits or services were provided while the physician was employed by or under contract with the carrier. Reimbursement for the health care services shall be pursuant to the same fee schedule used to reimburse for the services when the physician was employed by or under contract with the carrier.

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

This law was approved on January 18, 2000.

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

Specifically, this law:

- requires that coverage be provided for biologically-based mental illness under the same terms and conditions as provided for any other sickness under the contract;
- defines "biologically-based mental illness" as a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism;
- defines "same terms and conditions" to mean that a health insurance carrier cannot apply different copayments, deductibles or benefit limits to biologically-based mental health benefits than those applied to other medical or surgical benefits;

- stipulates that its provisions shall not be construed to change the manner in which a health insurance carrier determines:
    a. whether a mental health care service meets the medical necessity standard as established by the carrier; or
    b. which health care providers shall be entitled to reimbursement for providing services for mental illness under the contract; and
- requires the State Health Benefits Commission to provide notice to employees regarding the coverage required by this bill in accordance with the provisions of the bill and regulations adopted by the Commissioner of Health and Senior Services.

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

This law was approved on January 18, 2000.

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

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

Section 24: Amends N.J.S.A. 40A:10-6 to permit certain local units to establish health benefits funds for the provision of contributory or non-contributory self-funded or partially self-funded health benefits for employees or their dependents, or both. Boards of education, venture commissions, educational service commissions, county special services school districts, county vocational-technical schools, and county colleges are not included in the provision. Previously, the law only permitted local units to enter into contracts for health insurance and was not clear whether local units could be self insured for health insurance without specific statutory authority. This provision validates local unit health benefits funds operating prior to the effective date of this law.

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

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

HIPAA Requirements for 2001 — The State Health Benefits Commission has filed for exemption from the HIPAA mental health parity requirement with the federal Health Care Financing Administration for calendar year 2000. As a result, the maximum annual and lifetime dollar limits for mental health benefits under the Traditional Plan and NJ PLUS has not changed.

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

STATE MONTHLY ACTIVE GROUP

RATES EFFECTIVE 1/1/2002 TO 12/31/2002

	DESCRIPTION OF COVERAGE	STATE CONTRIBUTION	MAXIMUM EMPLOYEE CONTRIBUTION	TOTAL
NJ PLUS-#001	Single	$215.28	—	$215.28
	Member & Spouse	$469.23	—	$469.23
	Family	$558.51	—	$558.51
	Parent & Child	$323.87	—	$323.87
TRADITIONAL-#002	Single	$268.60	$89.53	$358.13
	Member & Spouse	$574.88	$191.62	$766.50
	Family	$684.21	$228.06	$912.27
	Parent & Child	$396.74	$132.24	$528.98
AETNA/USHC-#019	Single	$207.95	$10.94	$218.89
	Member & Spouse	$459.38	$24.17	$483.55
	Family	$534.30	$28.12	$562.42
	Parent & Child	$307.65	$16.19	$323.84
CIGNA HEALTHCARE-#020	Single	$232.22	$12.22	$244.44
	Member & Spouse	$506.52	$26.65	$533.17
	Family	$604.12	$31.79	$635.91
	Parent & Child	$348.57	$18.34	$366.91
OXFORD-#028	Single	$238.07	$12.52	$250.59
	Member & Spouse	$523.65	$27.56	$551.21
	Family	$618.87	$32.57	$651.44
	Parent & Child	$357.09	$18.79	$375.88
AMERIHEALTH-#033	Single	$227.79	$11.98	$239.77
	Member & Spouse	$506.97	$26.68	$533.65
	Family	$590.16	$31.06	$621.22
	Parent & Child	$336.24	$17.69	$353.93
HEALTH NET-#034	Single	$230.83	$12.14	$242.97
	Member & Spouse	$502.79	$26.46	$529.25
	Family	$610.34	$32.12	$642.46
	Parent & Child	$354.08	$18.63	$372.71
UNIVERSITY-#036	Single	$219.44	$11.54	$230.98
	Member & Spouse	$482.69	$25.40	$508.09
	Family	$570.48	$30.02	$600.50
	Parent & Child	$329.15	$17.32	$346.47
PRESCRIPTION DRUG PROGRAM-#201	Single	$82.34	—	$82.34
	Member & Spouse	$188.19	—	$188.19
	Family	$197.66	—	$197.66
	Parent & Child	$109.89	—	$109.89

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

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

LOCAL MONTHLY ACTIVE GROUP - EDUCATION EMPLOYERS

RATES EFFECTIVE 1/1/2002 TO 12/31/2002

PROGRAM	DESCRIPTION OF COVERAGE	EMPLOYER SINGLE COST	DEPENDENT COST	TOTAL
NJ PLUS-#001	Single	$222.26	—	$222.26
	Member & Spouse	$223.28	$271.39	$494.67
	Family	$223.66	$351.88	$575.54
	Parent & Child	$222.71	$105.48	$328.19
TRADITIONAL-#002	Single	$324.01	—	$324.01
	Member & Spouse	$325.03	$378.33	$703.36
	Family	$325.41	$497.68	$823.09
	Parent & Child	$324.46	$146.96	$471.42
AETNA/USHC-#019	Single	$295.33	—	$295.33
	Member & Spouse	$296.35	$343.16	$639.51
	Family	$296.73	$423.76	$720.49
	Parent & Child	$295.78	$110.87	$406.65
CIGNA HEALTHCARE-#020	Single	$320.88	—	$320.88
	Member & Spouse	$321.90	$367.22	$689.12
	Family	$322.28	$471.70	$793.98
	Parent & Child	$321.33	$128.38	$449.71
OXFORD-#028	Single	$272.54	—	$272.54
	Member & Spouse	$273.56	$325.93	$599.49
	Family	$273.94	$434.57	$708.51
	Parent & Child	$272.99	$135.80	$408.79
AMERIHEALTH-#033	Single	$316.64	—	$316.64
	Member & Spouse	$317.66	$387.16	$704.82
	Family	$318.04	$502.33	$820.37
	Parent & Child	$317.09	$150.28	$467.37
HEALTH NET-#034	Single	$268.86	—	$268.86
	Member & Spouse	$269.88	$315.78	$585.66
	Family	$270.26	$440.68	$710.94
	Parent & Child	$269.31	$143.13	$412.44
UNIVERSITY-#036	Single	$272.50	—	$272.50
	Member & Spouse	$273.52	$325.93	$599.45
	Family	$273.90	$434.56	$708.46
	Parent & Child	$272.95	$135.20	$408.15

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

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

LOCAL MONTHLY ACTIVE GROUP - EDUCATION EMPLOYERS

RATES EFFECTIVE 1/1/2002 TO 12/31/2002

PROGRAM	DESCRIPTION OF COVERAGE	EMPLOYER SINGLE COST	DEPENDENT COST	TOTAL
NJ PLUS-#001	Single	$197.95	—	$197.95
	Member & Spouse	$198.97	$241.59	$440.56
	Family	$199.35	$313.25	$512.60
	Parent & Child	$198.40	$93.90	$292.30
TRADITIONAL-#002	Single	$280.64	—	$280.64
	Member & Spouse	$281.66	$330.41	$612.07
	Family	$282.04	$433.42	$715.46
	Parent & Child	$281.09	$128.33	$409.42
AETNA/USHC-#019	Single	$218.89	—	$218.89
	Member & Spouse	$219.91	$263.64	$483.55
	Family	$220.29	$342.13	$562.42
	Parent & Child	$219.34	$104.50	$323.84
CIGNA HEALTHCARE-#020	Single	$244.44	—	$244.44
	Member & Spouse	$245.46	$287.71	$533.17
	Family	$245.84	$390.07	$635.91
	Parent & Child	$244.89	$122.02	$366.91
OXFORD-#028	Single	$250.59	—	$250.59
	Member & Spouse	$251.61	$299.60	$551.21
	Family	$251.99	$399.45	$651.44
	Parent & Child	$251.04	$124.84	$375.88
AMERIHEALTH-#033	Single	$239.77	—	$239.77
	Member & Spouse	$240.79	$292.86	$533.65
	Family	$241.17	$380.05	$621.22
	Parent & Child	$240.22	$113.71	$353.93
HEALTH NET-#034	Single	$242.97	—	$242.97
	Member & Spouse	$243.99	$285.26	$529.25
	Family	$244.37	$398.09	$642.46
	Parent & Child	$243.42	$129.29	$372.71
UNIVERSITY-#036	Single	$230.98	—	$230.98
	Member & Spouse	$232.00	$276.09	$508.09
	Family	$232.38	$368.12	$600.50
	Parent & Child	$231.43	$115.04	$346.47
PRESCRIPTION DRUG PROGRAM-#201	Single	$83.91	—	$83.91
	Member & Spouse	$83.91	$107.89	$191.80
	Family	$83.91	$117.76	$201.67
	Parent & Child	$83.91	$28.11	$112.02

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

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

LOCAL MONTHLY ACTIVE GROUP - (EXCLUDES EDUCATION EMPLOYERS)

RATES EFFECTIVE 1/1/2002 TO 12/31/2002

PROGRAM	DESCRIPTION OF COVERAGE	EMPLOYER SINGLE COST	DEPENDENT COST	TOTAL
NJ PLUS-#001	Single	$242.11	—	$242.11
	Member & Spouse	$243.13	$295.71	$538.84
	Family	$243.51	$383.44	$626.95
	Parent & Child	$242.56	$114.94	$357.50
TRADITIONAL-#002	Single	$337.33	—	$337.33
	Member & Spouse	$338.35	$393.96	$732.31
	Family	$338.73	$518.26	$856.99
	Parent & Child	$337.78	$153.03	$490.81
AETNA/USHC-#019	Single	$295.33	—	$295.33
	Member & Spouse	$296.35	$343.16	$639.51
	Family	$296.73	$423.76	$720.49
	Parent & Child	$295.78	$110.87	$406.65
CIGNA HEALTHCARE-#020	Single	$320.88	—	$320.88
	Member & Spouse	$321.90	$367.22	$689.12
	Family	$322.28	$471.70	$793.98
	Parent & Child	$321.33	$128.38	$449.71
OXFORD-#028	Single	$272.54	—	$272.54
	Member & Spouse	$273.56	$325.93	$599.49
	Family	$273.94	$434.57	$708.51
	Parent & Child	$272.99	$135.80	$408.79
AMERIHEALTH-#033	Single	$316.64	—	$316.64
	Member & Spouse	$317.66	$387.16	$704.82
	Family	$318.04	$502.33	$820.37
	Parent & Child	$317.09	$150.28	$467.37
HEALTH NET-#034	Single	$268.86	—	$268.86
	Member & Spouse	$269.88	$315.78	$585.66
	Family	$270.26	$440.68	$710.94
	Parent & Child	$269.31	$143.13	$412.44
UNIVERSITY-#036	Single	$272.50	—	$272.50
	Member & Spouse	$273.52	$325.93	$599.45
	Family	$273.90	$434.56	$708.46
	Parent & Child	$272.95	$135.20	$408.15

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

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

LOCAL MONTHLY ACTIVE GROUP - (EXCLUDES EDUCATION EMPLOYERS)

RATES EFFECTIVE 1/1/2002 TO 12/31/2002

PROGRAM	DESCRIPTION OF COVERAGE	EMPLOYER SINGLE COST	DEPENDENT COST	TOTAL
NJ PLUS-#001	Single	$227.75	—	$227.75
	Member & Spouse	$228.95	$277.96	$506.91
	Family	$229.39	$360.41	$589.80
	Parent & Child	$228.28	$108.02	$336.30
TRADITIONAL-#002	Single	$308.94	—	$308.94
	Member & Spouse	$310.14	$363.69	$673.83
	Family	$310.58	$477.08	$787.66
	Parent & Child	$309.47	$141.27	$450.74
AETNA/USHC-#019	Single	$218.89	—	$218.89
	Member & Spouse	$219.91	$263.64	$483.55
	Family	$220.29	$342.13	$562.42
	Parent & Child	$219.34	$104.50	$323.84
CIGNA HEALTHCARE-#020	Single	$244.44	—	$244.44
	Member & Spouse	$245.46	$287.71	$533.17
	Family	$245.84	$390.07	$635.91
	Parent & Child	$244.89	$122.02	$366.91
OXFORD-#028	Single	$250.59	—	$250.59
	Member & Spouse	$251.61	$299.60	$551.21
	Family	$251.99	$399.45	$651.44
	Parent & Child	$251.04	$124.84	$375.88
AMERIHEALTH-#033	Single	$239.77	—	$239.77
	Member & Spouse	$240.79	$292.86	$533.65
	Family	$241.17	$380.05	$621.22
	Parent & Child	$240.22	$113.71	$353.93
HEALTH NET-#034	Single	$242.97	—	$242.97
	Member & Spouse	$243.99	$285.26	$529.25
	Family	$244.37	$398.09	$642.46
	Parent & Child	$243.42	$129.29	$372.71
UNIVERSITY-#036	Single	$230.98	—	$230.98
	Member & Spouse	$232.00	$276.09	$508.09
	Family	$232.38	$368.12	$600.50
	Parent & Child	$231.43	$115.04	$346.47
PRESCRIPTION DRUG PROGRAM-#201	Single	$83.91	—	$83.91
	Member & Spouse	$83.91	$107.89	$191.80
	Family	$83.91	$117.76	$201.67
	Parent & Child	$83.91	$28.11	$112.02

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

DENTAL PROGRAM

MONTHLY GROUP RATES EFFECTIVE 1/1/2002 TO 12/31/2002

DENTAL EXPENSE PLAN - STATE MONTHLY GROUP — #399

	DESCRIPTION OF COVERAGE	STATE CONTRIBUTION	EMPLOYEE CONTRIBUTION	TOTAL
DENTAL EXPENSE PLAN - #399	SINGLE	$20.08	$20.08	$40.16
	MEMBER & SPOUSE	$30.95	$30.95	$61.90
	FAMILY	$51.34	$51.34	$102.68
	PARENT & CHILD	$40.45	$40.44	$80.89
DENTAL PROVIDER ORGANIZATIONS (DPO)				
GROUP DENTAL HEALTH ADMINISTRATORS (DPO #306) HEALTHPLEX (DPO #307) PROTECTIVE (DPO #308) FLAGSHIP HEALTH SYSTEMS, INC. (DPO #312) HORIZON DENTAL CHOICE (DPO #317)				
	SINGLE	$8.38	$8.55	$16.93
	MEMBER & SPOUSE	$14.56	$14.87	$29.43
	FAMILY	$23.82	$24.33	$48.15
	PARENT & CHILD	$17.69	$17.99	$35.68
BENECARE (DPO #301)	SINGLE	$11.01	$8.55	$19.56
	MEMBER & SPOUSE	$19.12	$14.87	$33.99
	FAMILY	$31.29	$24.33	$55.62
	PARENT & CHILD	$23.22	$17.99	$41.21
COMMUNITY DENTAL (DPO #302)	SINGLE	$10.12	$8.55	$18.67
	MEMBER & SPOUSE	$17.58	$14.87	$32.45
	FAMILY	$28.76	$24.33	$53.09
	PARENT & CHILD	$21.34	$17.99	$39.33
CIGNA (DPO #305)	SINGLE	$8.80	$8.55	$17.35
	MEMBER & SPOUSE	$15.30	$14.87	$30.17
	FAMILY	$25.02	$24.33	$49.35
	PARENT & CHILD	$18.58	$17.99	$36.57
UNITY (DPO #311)	SINGLE	$7.53	$8.55	$16.08
	MEMBER & SPOUSE	$13.09	$14.87	$27.96
	FAMILY	$21.41	$24.33	$45.74
	PARENT & CHILD	$15.91	$17.99	$33.90
AETNA/USHC (DPO #319)	SINGLE	$7.28	$8.55	$15.83
	MEMBER & SPOUSE	$12.65	$14.87	$27.52
	FAMILY	$20.69	$24.33	$45.02
	PARENT & CHILD	$15.37	$17.99	$33.36