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, 2003

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 2003

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 2003 State Health Benefits Program Annual Report in accordance with the provisions of N.J.S.A. 52:14-17.27.

The Division has been vigorously looking into ways to reduce healthcare plan costs without diminishing services and benefits for participating SHBP public employers and their active and retired members.

In fiscal year 2003, the State Health Benefits Commission approved the contract between AdvancePCS and Horizon Blue Cross/Blue Shield of New Jersey (BCB-SNJ) that would establish AdvancePCS as the new Prescription Benefit Manager (PBM). AdvancePCS will administer prescription drug benefits of the SHBP Employee Prescription Drug Plan as well as for the Traditional and NJ PLUS medical plans. AdvancePCS manages a comprehensive retail pharmacy network consisting of over 96 percent of the pharmacies in New Jersey and 95 percent of the pharmacies nationwide. It is expected this change will save the State of New Jersey approximately $10,000,000 in additional discounts off of the average wholesale drug price and the dispensing fee charges.

We will continue to pursue new and innovative benefit designs and concepts that will enhance the care of 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

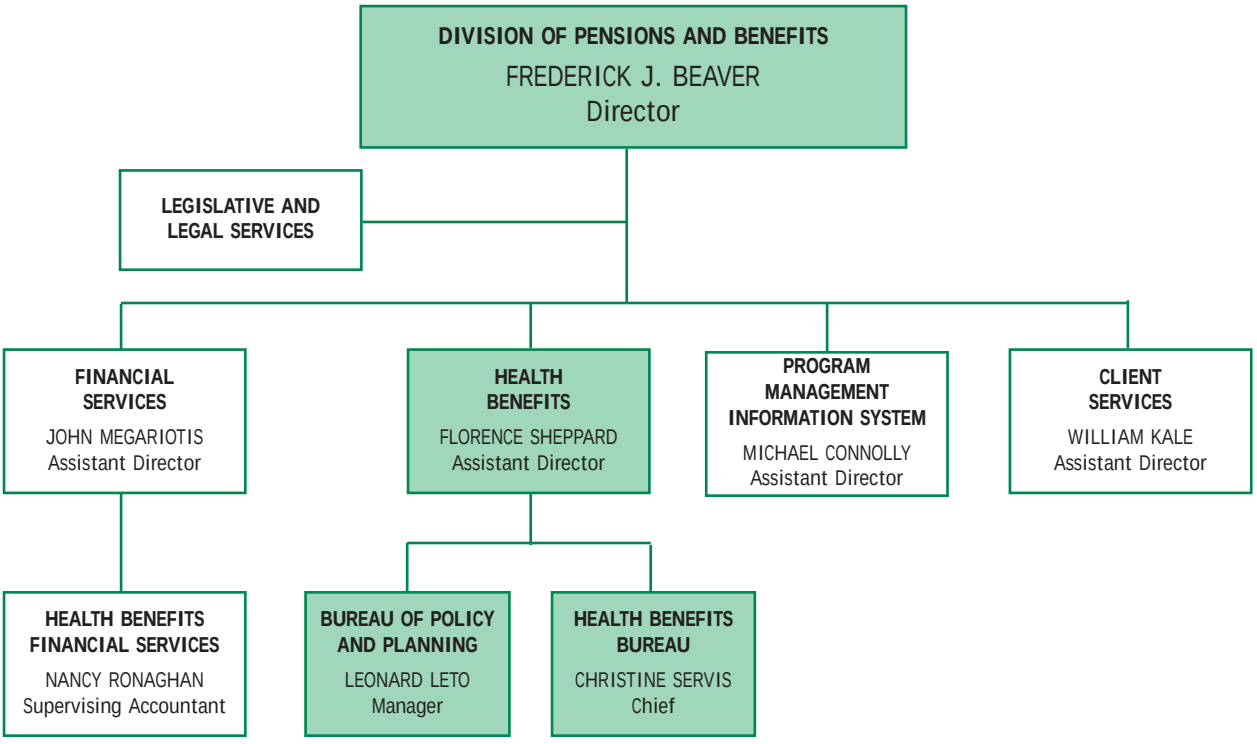
The State Health Benefits Program is committed to a standard of excellence that delivers quality health care in an efficient and cost effective manner.

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, 2003



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.

The operations of the SHBP are handled by two bureaus under the direction of an Assistant Director.

Health Benefits Bureau

The Health Benefits Bureau is responsible for all SHBP enrollment activities encompassing 7 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 and their dependents. Chapter 125, P.L. 1964 extended the program to include employees of local government at the option of each public employer.

Chapter 337 of the Public Laws of 1973 (C.26:2J-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 carved-out Prescription Drug Program was initiated as a result of union negotiations for certain State employees effective December 1, 1974. The passage of Chapter 41, P.L. 1976 extended this coverage to all eligible State employees. The State Health Benefits Commission offered the program to local employers that participated in the SHBP on July 1, 1993.

The State Dental Program was established February 1, 1978 for State employees only. Initially only one plan was offered: a traditional indemnity plan known as the New Jersey State Dental Expense Benefits Program. The Program expanded in June 1984 to include Dental Provider Organizations (DPOs). 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, as well as 3 HMOs, are self-insured. The dental indemnity plan is also self-insured, with administrative services provided by Aetna. Currently two 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 of multiple programs offering comprehensive coverage where employees choose a primary care physician from a closed network of participating providers to manage all care provided. Most HMOs cover the entire State and adjacent counties in neighboring states where licensed. For Medicare eligible retirees, all State participating HMOs coordinate their benefits with Medicare. Several self-insured HMOs now offer coverage in the following states: Pennsylvania, Connecticut, Delaware, Arizona, South Carolina, and Washington, D.C.; parts of California, New York, Florida, Illinois, Indiana, North Carolina, Texas, Virginia, Georgia, and West Virginia.

Dental Program

State employees may choose a traditional indemnity plan called the Dental Expense Plan or prepaid dental HMOs, called Dental Provider Organizations. Dental coverage is optional. State employees who opt for coverage pay 50% of the overall cost through payroll deductions. 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 Employee Prescription Drug Plan is currently administered by Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) through AdvancePCS.

For each 30-day supply obtained at a retail pharmacy, participants pay a $1.00 copayment for generic drugs and a $5.00 copayment 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

Health Maintenance Organization

Effective August 1, 2002, University Health Plans HMO (UHP) terminated its participation in the SHBP.

Administrative Change

The Health Net HMO plan benefit design available to participants of the SHBP is on a self-insured basis effective January 1, 2003.

Coordination of Benefits

The State Health Benefits Commission adopted N.J.A.C. 11:4-28 effective January 1, 2003 for all self-insured plans participating in the State Health Benefits Program. This provision details directions on coordinating benefits for persons covered by two or more benefit plans when payment under at least one of the plans is to a network provider.

HIPAA Requirements

The State Health Benefits Commission has filed for exemption from the HIPAA mental health parity requirement with the federal Health Care Financing Administration for calendar year 2003. As a result, the maximum annual and lifetime dollar limits for mental health benefits under the Traditional Plan and NJ PLUS have not changed.

2003 Significant Legislation

Chapter 3, P.L. 2003

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

The new law amends these statutes in two ways:

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

This law was effective January 27, 2003.

Chapter 27, P.L. 2003

This law requires:

- an employer that provides a health benefits plan to its employees or their dependents to provide 30 days' prior written notice to its employees if the plan is terminated, and

2003 Significant Legislation, Continued

- a health insurer that increases premium rates upon the renewal of a health benefits plan to provide 60 days' prior written notice of the amount of a proposed increase to the employer that purchased the plans.

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

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

This law was effective May 9, 2003.

Chapter 71, P.L. 2003

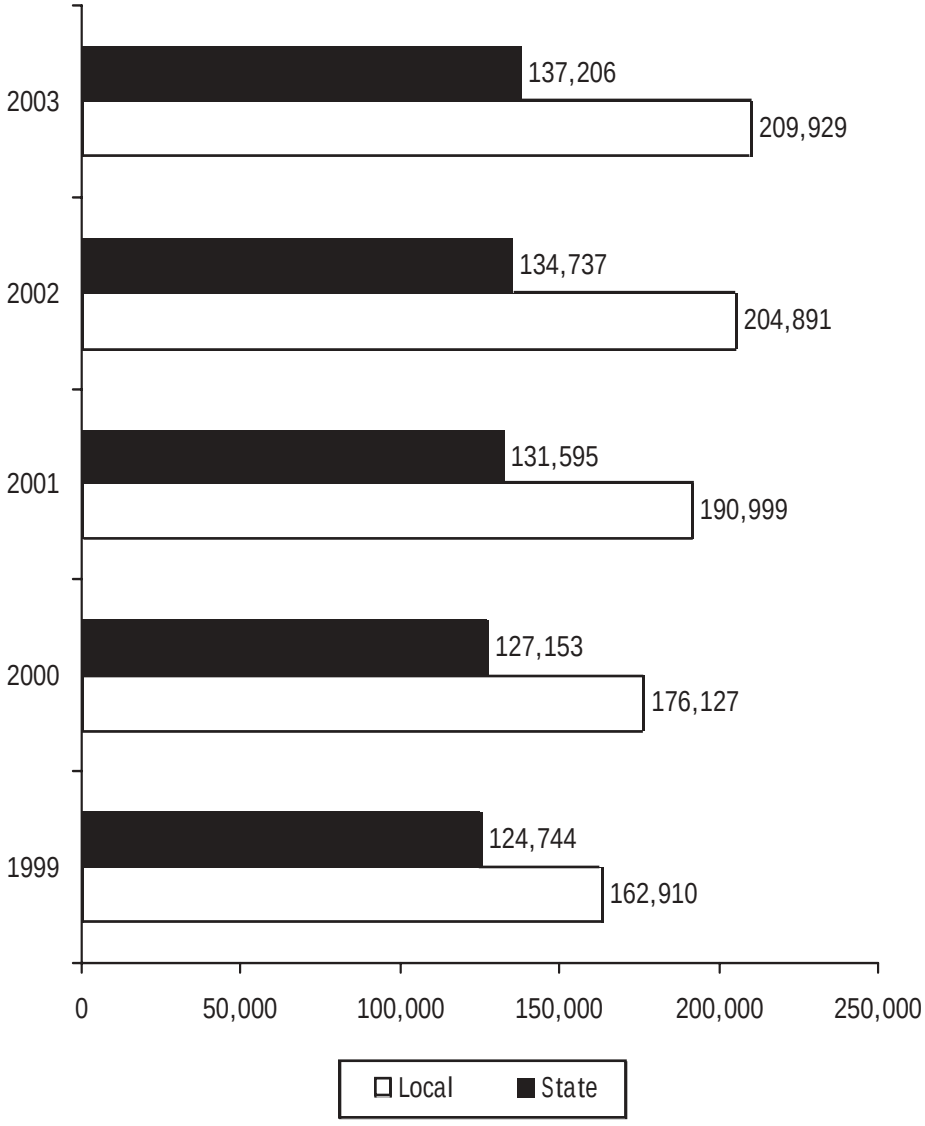
This law provides for the addition of two members to the membership of the State Health Benefits Commission. The current members are the State Treasurer who serves as the Chairman, the Commissioner of Banking and Insurance and the Commissioner of Personnel.

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

This law was effective May 5, 2003.

SHBP Membership

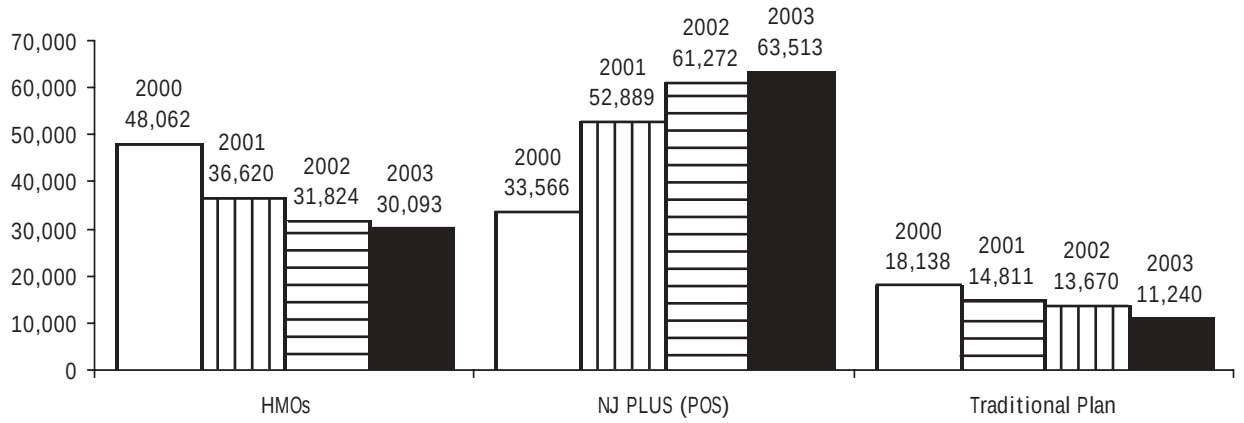
State and Local Employees and Retirees
Fiscal Years 1999 - 2003



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

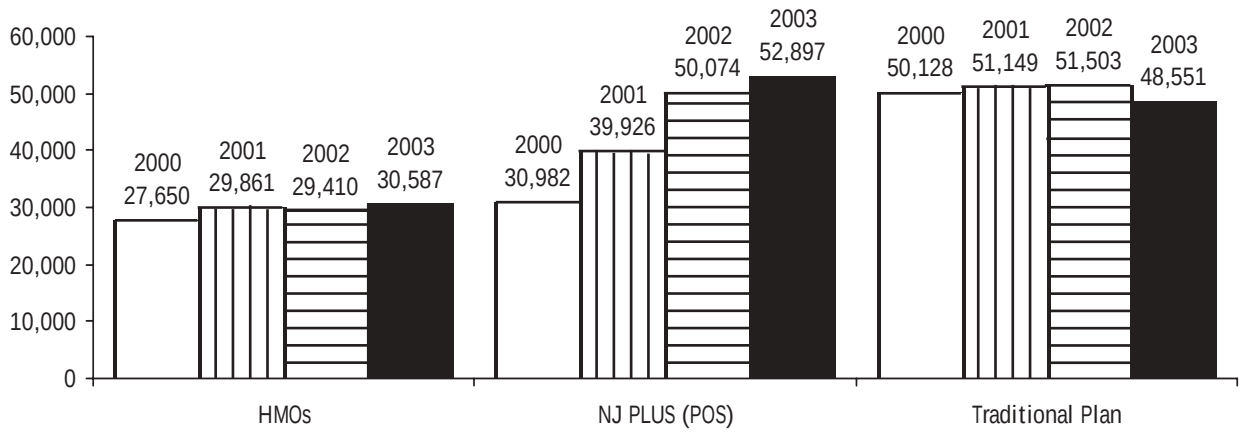
SHBP Membership

State Employer
Active Employees - Plan Participation
Fiscal Years 2000 - 2003



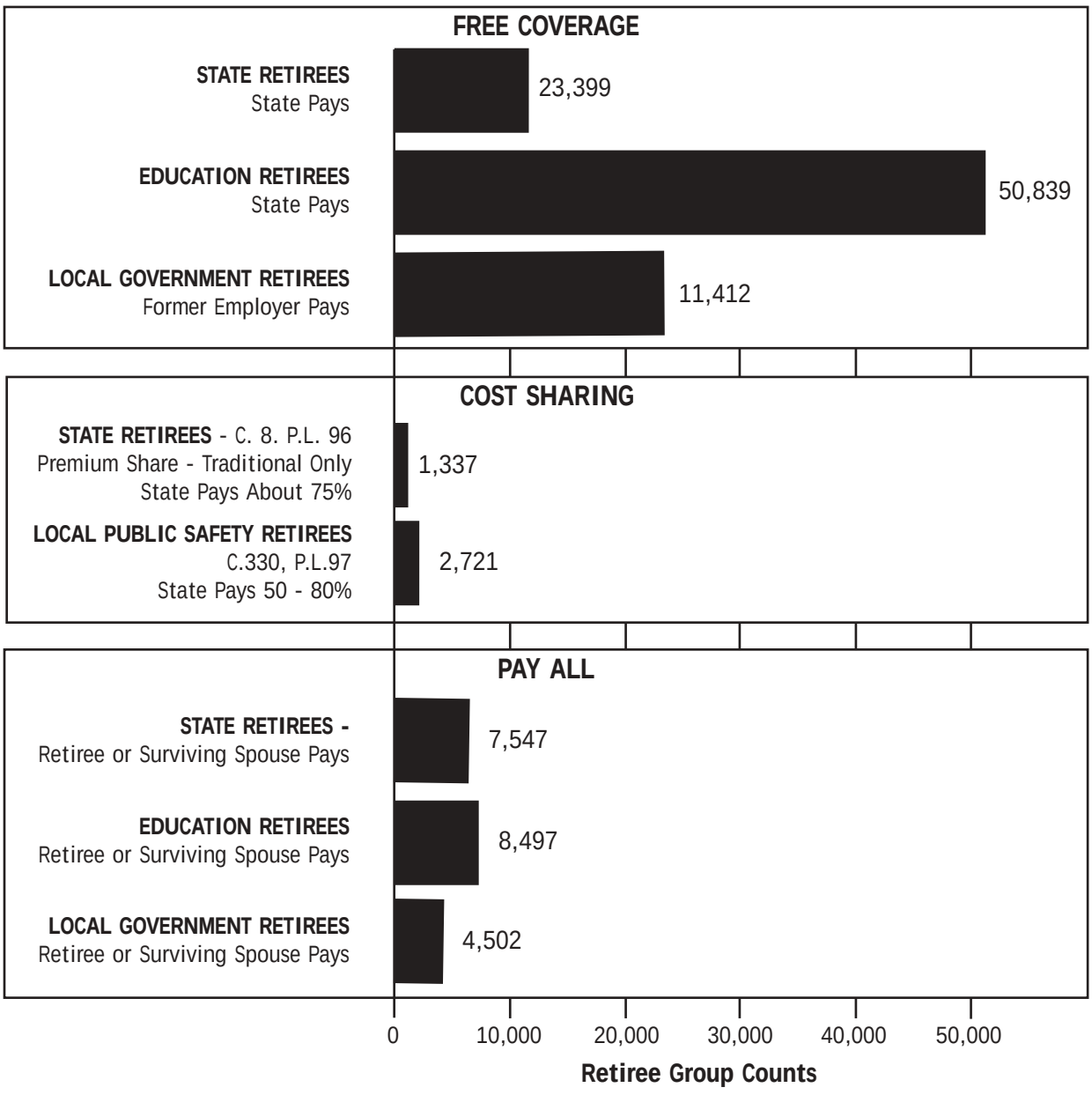
Data as of the fiscal year ended June 30th.

Local Employers
Active Employees - Plan Participation
Fiscal Years 2000-2003



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, 2003

EMPLOYEES

PLAN NAME	EMPLOYEES	AS A % OF EMPLOYEE ENROLLMENT	DEPENDENTS OF EMPLOYEES	EMPLOYEES AND DEPENDENTS
NJ PLUS	63,513	60.58%	94,420	157,933
Traditional	11,240	10.72%	11,894	23,134
Aetna, Inc.	21,634	20.63%	36,838	58,472
Cigna	2,565	2.45%	3,897	6,462
Oxford	2,186	2.09%	3,641	5,827
Amerihealth	1,565	1.49%	2,485	4,050
Healthnet	2,143	2.04%	3,511	5,654
TOTAL	**104,846**	**100.00%**	**156,686**	**261,532**

RETIREES

PLAN NAME	RETIREES	AS A % OF RETIREE ENROLLMENT	DEPENDENTS OF RETIREES	RETIREES AND DEPENDENTS
NJ PLUS	7,893	24.39%	6,228	14,121
Traditional	18,944	58.54%	10,581	29,525
Aetna, Inc.	4,126	12.75%	3,318	7,444
Cigna	529	1.64%	439	968
Oxford	270	0.83%	175	445
Amerihealth	251	0.78%	214	465
Healthnet	347	1.07%	242	589
TOTAL	**32,360**	**100.00%**	**21,197**	**53,557**

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	71,406	100,648	172,054	54.61%
Traditional	30,184	22,475	52,659	16.71%
Aetna, Inc.	25,760	40,156	65,916	20.92%
Cigna	3,094	4,336	7,430	2.36%
Oxford	2,456	3,816	6,272	1.99%
Amerihealth	1,816	2,699	4,515	1.43%
Healthnet	2,490	3,753	6,243	1.98%
TOTAL	**137,206**	**177,883**	**315,089**	**100.00%**

SHBP Enrollment — Local Employer Group — Education

As of June 30, 2003

EMPLOYEES

PLAN NAME	EMPLOYEES	AS A % OF EMPLOYEE ENROLLMENT	DEPENDENTS OF EMPLOYEES	EMPLOYEES AND DEPENDENTS
NJ PLUS	32,597	38.72%	51,132	83,729
Traditional	34,061	40.45%	45,319	79,380
Aetna, Inc.	10,436	12.39%	16,732	27,168
Cigna	1,896	2.25%	3,150	5,046
Oxford	2,293	2.72%	3,854	6,147
Amerihealth	1,208	1.43%	2,002	3,210
Healthnet	1,716	2.04%	2,881	4,597
TOTAL	**84,207**	**100.00%**	**125,070**	**209,277**

RETIREES

PLAN NAME	RETIREES	AS A % OF RETIREE ENROLLMENT	DEPENDENTS OF RETIREES	RETIREES AND DEPENDENTS
NJ PLUS	7,402	12.49%	5,764	13,166
Traditional	47,896	80.83%	28,957	76,853
Aetna, Inc.	2,837	4.79%	2,044	4,881
Cigna	499	0.84%	414	913
Oxford	136	0.23%	75	211
Amerihealth	316	0.53%	296	612
Healthnet	168	0.29%	110	278
TOTAL	**59,254**	**100.00%**	**37,660**	**96,914**

BOTH EMPLOYEES AND RETIREES

PLAN NAME	EMPLOYEES AND RETIREES	DEPENDENTS OF EMPLOYEES AND RETIREES	TOTAL	AS A % OF ALL ENROLLMENT (TOTAL LIVES)
NJ PLUS	39,999	56,896	96,895	31.64%
Traditional	81,957	74,276	156,233	51.02%
Aetna, Inc.	13,273	18,776	32,049	10.47%
Cigna	2,395	3,564	5,959	1.95%
Oxford	2,429	3,929	6,358	2.08%
Amerihealth	1,524	2,298	3,822	1.25%
Healthnet	1,884	2,991	4,875	1.59%
TOTAL	**143,461**	**162,730**	**306,191**	**100.00%**

SHBP Enrollment — Local Employer Group — Government Employers

As of June 30, 2003

EMPLOYEES

PLAN NAME	EMPLOYEES	AS A % OF EMPLOYEE ENROLLMENT	DEPENDENTS OF EMPLOYEES	EMPLOYEES AND DEPENDENTS
NJ PLUS	20,300	42.44%	34,533	54,833
Traditional	14,490	30.30%	20,696	35,186
Aetna, Inc.	7,775	16.25%	13,376	21,151
Cigna	1,476	3.09%	2,911	4,387
Oxford	1,048	2.19%	2,234	3,282
Amerihealth	816	1.71%	1,354	2,170
Healthnet	1,923	4.02%	3,490	5,413
TOTAL	**47,828**	**100.00%**	**78,594**	**126,422**

RETIREES

PLAN NAME	RETIREES	AS A % OF RETIREE ENROLLMENT	DEPENDENTS OF RETIREES	RETIREES AND DEPENDENTS
NJ PLUS	3,083	16.54%	2,777	5,860
Traditional	13,283	71.26%	8,597	21,880
Aetna, Inc.	1,359	7.29%	1,427	2,786
Cigna	317	1.70%	368	685
Oxford	239	1.28%	262	501
Healthnet	135	0.72%	145	280
Physicians	224	1.21%	270	494
TOTAL	**18,640**	**100.00%**	**13,846**	**32,486**

BOTH EMPLOYEES AND RETIREES

PLAN NAME	EMPLOYEES AND RETIREES	DEPENDENTS OF EMPLOYEES AND RETIREES	TOTAL	AS A % OF ALL ENROLLMENT (TOTAL LIVES)
NJ PLUS	23,383	37,310	60,693	38.19%
Traditional	27,773	29,293	57,066	35.91%
Aetna, Inc.	9,134	14,803	23,937	15.06%
Cigna	1,793	3,279	5,072	3.19%
Oxford	1,287	2,496	3,783	2.38%
Amerihealth	951	1,499	2,450	1.54%
Healthnet	2,147	3,760	5,907	3.73%
TOTAL	**66,468**	**92,440**	**158,908**	**100.00%**

SHBP Enrollment by State and Local Employer Groups

As of June 30, 2003

EMPLOYEE

PLAN NAME	EMPLOYEES	AS A % OF EMPLOYEE ENROLLMENT	DEPENDENTS OF EMPLOYEES	EMPLOYEES AND DEPENDENTS
NJ PLUS	116,410	49.14%	180,085	296,495
Traditional	59,791	25.25%	77,909	137,700
Aetna, Inc.	39,845	16.82%	66,946	106,791
Cigna	5,937	2.50%	9,958	15,895
Oxford	5,527	2.33%	9,729	15,256
Amerihealth	3,589	1.52%	5,841	9,430
Healthnet	5,782	2.44%	9,882	15,664
TOTAL	**236,881**	**100.00%**	**360,350**	**597,231**

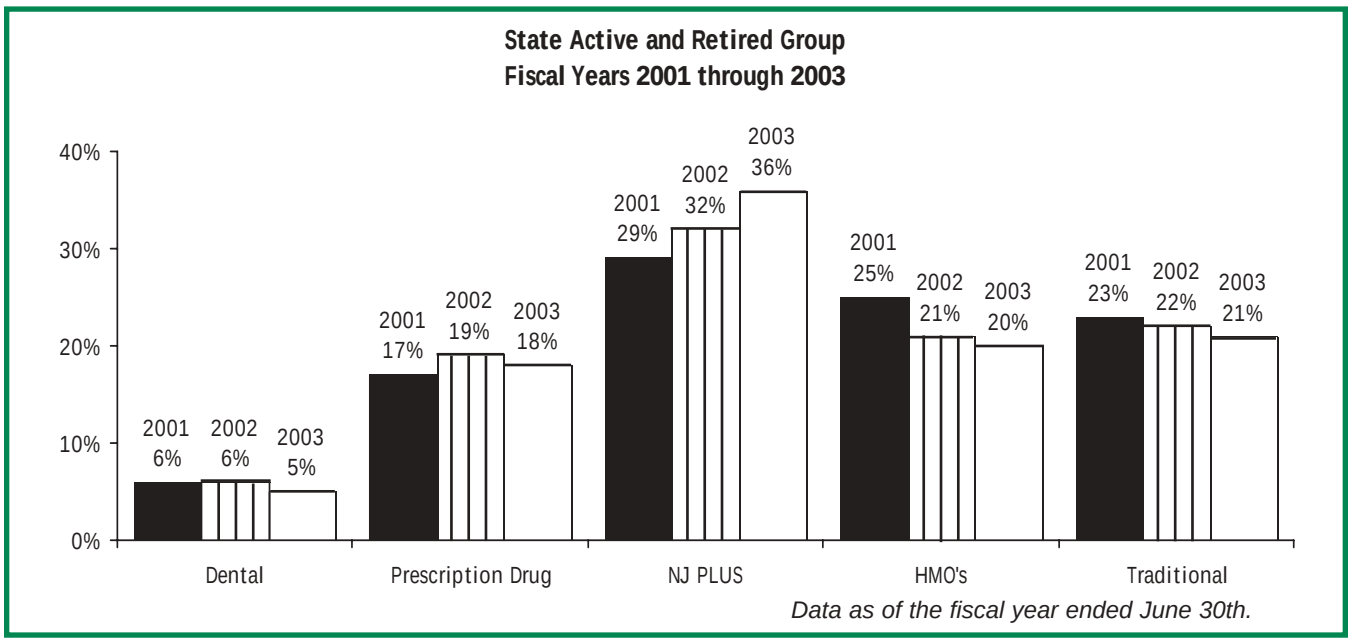
RETIREES

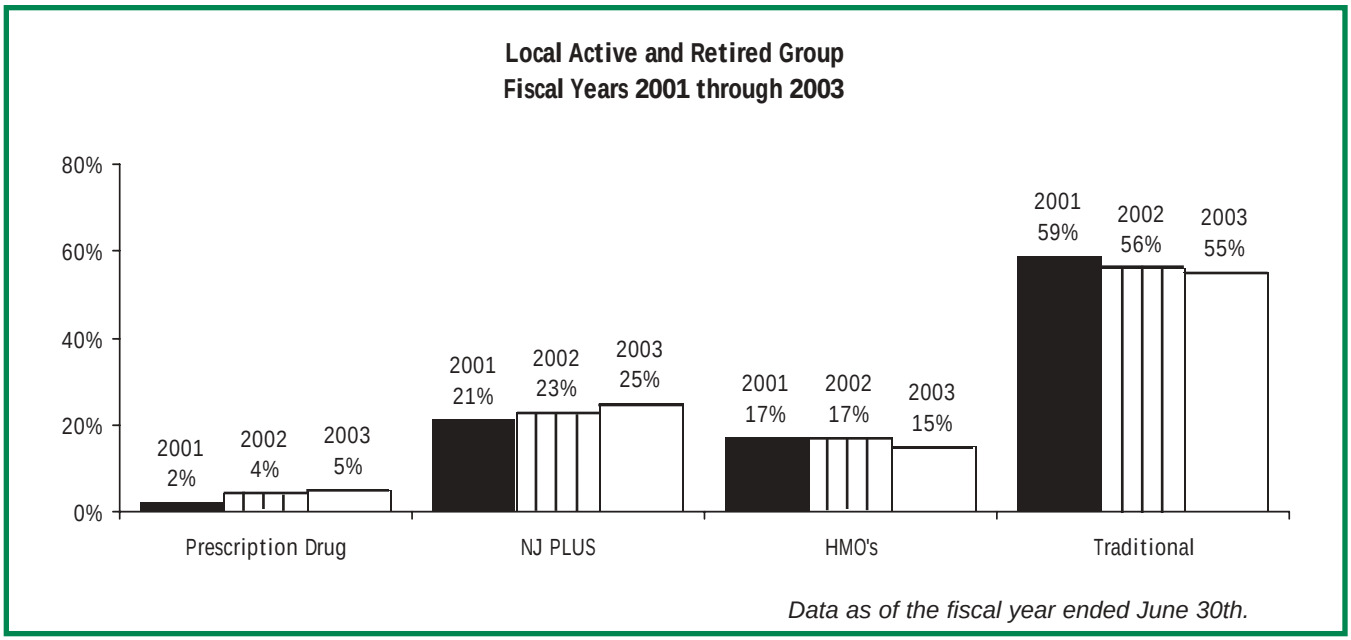
PLAN NAME	RETIREES	AS A % OF RETIREE ENROLLMENT	DEPENDENTS OF RETIREES	RETIREES AND DEPENDENTS
NJ PLUS	18,378	16.67%	14,769	33,147
Traditional	80,123	72.67%	48,135	128,258
Aetna, Inc.	8,322	7.55%	6,789	15,111
Cigna	1,345	1.22%	1,221	2,566
Oxford	645	0.58%	512	1,157
Amerihealth	702	0.64%	655	1,357
Healthnet	739	0.67%	622	1,361
TOTAL	**110,254**	**100.00%**	**72,703**	**182,957**

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	134,788	194,854	329,642	42.25%
Traditional	139,914	126,044	265,958	34.09%
Aetna, Inc.	48,167	73,735	121,902	15.62%
Cigna	7,282	11,179	18,461	2.37%
Oxford	6,172	10,241	16,413	2.10%
Amerihealth	4,291	6,496	10,787	1.38%
Healthnet	6,521	10,504	17,025	2.19%
TOTAL	**347,135**	**433,053**	**780,188**	**100.00%**

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





SHBP Local Participation 1996 - 2003

	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**
JAN 2003	5	314	300	267	22	908	35	**943**
JUL 2003	5	311	308	274	22	920	33	**953**

* 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, 2003

PLAN NAME	ESTIMATED STATE EMPLOYEE CONTRACTS	AS A % OF ALL EMPLOYEES	AS A % OF ALL DENTAL CONTRACTS
DENTAL PROVIDER ORGANIZATIONS			
Unity Dental	4,433	4.2%	5%
International HealthCare	4,575	4.4%	5%
Atlantic Southern	6,361	6.1%	7%
Fortis	2,931	2.8%	3%
Flagship Health	2,025	1.9%	2%
Community Dental	1,659	1.6%	2%
Horizon Healthcare Dental	4,924	4.7%	5%
Aetna DMO	10,126	9.7%	11%
Group Dental	373	.3%	0%
Dental Group of New Jersey	55	0.0%	0%
Cigna Dental Health	6,494	6.2%	7%
Subtotals	**43,956**	**41.9%**	**47%**
Dental Expense Plan	49,873	47.6%	53%
Employees that did not elect coverage	11,017	10.5%	N/A
Totals	**104,846**	**100%**	**100%**

STATE OF NEW JERSEY
HEALTH BENEFITS PROGRAM FUNDS, DENTAL EXPENSE
PROGRAM FUND AND PRESCRIPTION DRUG PROGRAM FUNDS
June 30, 2003

INDEX

KPMG LLP
New Jersey Headquarters
150 John F. Kennedy Parkway
Short Hills, NJ 07078

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, 2003 as listed in the accompanying table of contents. 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, 2003, 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, 2003, 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.

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 19, 2003

STATE OF NEW JERSEY
HEALTH BENEFITS PROGRAM FUNDS, DENTAL EXPENSE

PROGRAM FUND AND PRESCRIPTION DRUG PROGRAM FUNDS

Management's Discussion and Analysis

June 30, 2003

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, 2003. Please read it in conjunction with the basic financial statements and financial statement footnotes which follow this discussion.

FINANCIAL HIGHLIGHTS

Government-wide Financial Statements

Governmental Activities:

- For Health Benefits Program-State, net assets decreased by $2.8 million as a result of operations from ($92.5) million to ($95.3) million. For Prescription Drug Program-State, net assets increased by $18.5 million from $6.1 million to $24.6 million. For Dental Expense Program, net assets decreased by $0.8 million from $17.1 million to $16.3 million.
- Revenues recognized during the year were as follows: $816.4 million for the Health Benefits Program-State; $191.3 million for the Prescription Drug Program-State; $56.1 million for the Dental Expense Program.
- Expenses incurred during the year were as follows: $816.2 million for the Health Benefits Program-State; $175.8 million for the Prescription Drug Program-State; $56.9 million for the Dental Expense Program.

Business-Type Activities:

- For Health Benefits Program-Local, net assets increased by $117.8 million as a result of operations from ($59.7) million to $58.1 million. For Prescription Drug Program-Local, net assets increased by $3.1 million from $5.2 million to $8.3 million.
- For the Health Benefits Program-Local and the Prescription Drug Program-Local, revenues recognized during the year were $1.4 billion and $65.7 million, respectively.
- For Health Benefits Program-Local and the Prescription Drug Program-Local, expenses incurred during the year were $1.3 billion and $62.6 million, respectively.

OVERVIEW OF THE FINANCIAL STATEMENTS

Government-wide financial statements

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

Governmental Activities:

Health Benefits Program – State

Prescription Drug Program – State

Dental Expense Program

Business-Type Activities:

Health Benefits Program – Local

Prescription Drug Program – Local

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

Fund financial statements

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

Governmental Funds:

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

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

Proprietary Funds:

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

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

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

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

FINANCIAL ANALYSIS

STATEMENT OF NET ASSETS (DEFICIT)

***Governmental Activities*:**
Assets mainly consist of cash, investments, and contributions due from members, participating employers and former members who are covered under the rules of the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and contributions due from the PERS and the TPAF to provide funding for post-retirement medical benefits. Between fiscal years 2002 and 2003, total assets increased by $20.1 million or 27.7% from $72.5 million to $92.6 million. The increase in total assets is mainly due to increase in contributions from members and the State.

Liabilities mainly consist of outstanding medical and long-term disability claim payments, including incurred but not reported (IBNR) claims. Total liabilities increased by $5.3 million or 3.7% from $141.7 million to $147 million due to the increase in IBNR.

Net assets increased by $14.8 million or 21.4% from ($69.2) million to ($54.4) million due to increase in revenues.

***Business-Type Activities*:**
Assets mainly consist of cash, investments, contributions due from members, participating employers, and former members who are covered under the rules of COBRA. Between fiscal years 2002 and 2003, total assets increased by $133.8 million or 93.2% from $143.7 million to $277.5 million. The increase in total assets is mainly due to increase in contributions from members and local employers.

Liabilities mainly consist of outstanding claim payments and IBNR claims. Total liabilities increased by $13.0 million or 6.5% since the prior year from $198.1 million to $211.1 million due to increase in incurred claims.

Net assets increased by $120.9 million or 221.9% from ($54.5) million to $66.4 million due to revenues exceeding expenses.

STATEMENT OF ACTIVITIES

REVENUES - ADDITIONS TO NET ASSETS (DEFICIT)

Governmental Activities:

	2003	2002	Increase (Decrease)
Member Contributions	$98,538,421	$92,615,336	$5,923,085
Employer Contributions	964,089,279	783,945,829	180,143,450
CMF Investment & Other	1,157,744	2,403,464	(1,245,720)
Totals	$1,063,785,444	$878,964,629	$184,820,815

Business-Type Activities:

	2003	2002	Increase (Decrease)
Member Contributions	$75,340,822	$62,065,953	$13,274,869
Employer Contributions	1,411,263,887	1,098,924,109	312,339,778
CMF Investment & Other	1,378,803	2,484,915	(1,106,112)
Totals	$1,487,983,512	$1,163,474,977	$324,508,535

Revenues primarily consist of member and employer contributions and earnings from Cash Management Fund (CMF) Investment activities. For the Governmental Activities, revenues increased by 21% from $879 million to $1.1 billion. For the Business-Type Activities, total revenues increased by 27.9% from $1.2 billion to $1.5 billion. The increase in revenues is attributable to an increase in the premium rates for the health, dental, and prescription drug plans. Member contributions increased by 6.4% for the Governmental Activities and by 21.4% for the Business-Type Activities for the same reason. The reduction in investment and other revenues is primarily due to lower interest earnings from CMF holdings.

EXPENSES - DEDUCTIONS FROM NET ASSETS (DEFICIT)

Governmental Activities:

	2003	2002	Increase (Decrease)
Benefits	$1,046,043,657	$924,003,561	$122,040,096
Administrative Expenses	2,919,206	2,346,803	572,403
Totals	$1,048,962,863	$926,350,364	$122,612,499

Expenses primarily consist of claim charges for the self-insured health, prescription drug, and dental plans, premium charges for the insured health and dental programs, and administrative expenses. During the year, expenses increased by $122.6 million or 13.2% for the Governmental Activities. For the insured plans, expenses increased due to the higher premium rates for calendar year 2003. The average premium rate increase for all plans is 17.5% for active members and 24.2% for retirees in calendar year 2003. For the self-insured plans, the increase in benefit expenses was due to higher claim charges, which is attributable to the rising cost of health services.

Business-Type Activities:

	2003	2002	Increase (Decrease)
Benefits	$1,362,676,860	$1,212,090,971	$150,585,889
Administrative Expenses	4,378,810	5,475,874	(1,097,064)
Totals	$1,367,055,670	$1,217,566,845	$149,488,825

Expenses primarily consist of claim charges for the self-insured health and prescription drug plans, premium charges for the insured health and administrative expenses. During the year, expenses increased by $149.5 million or 12.3% for the Business-Type Activities. For the insured plans, expenses increased due to higher premium rates for calendar year 2003**.** The average premium rate increase for all plans is 20.2% for active members and 26.6% for retirees in calendar year 2003. For the self-insured plans, the increase in benefit expenses was due to higher claim charges, which is attributable to the rising cost of health services.

OVERALL FINANCIAL CONDITION OF THE FUNDS

For the State Health Benefits Program Fund - State and Local, contributions received by the Funds to pay the premiums for covered members are now keeping pace with the rising health costs and produce a necessary reserve. Management anticipates that through further rate actions and other initiatives, the Funds will maintain sufficient reserves.

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

CONTACTING SYSTEM FINANCIAL MANAGEMENT

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

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

Statement of Net Assets (Deficit)

June 30, 2003

	GOVERNMENTAL ACTIVITIES	BUSINESS-TYPE ACTIVITIES	TOTAL
Assets:			
Cash and cash equivalents	$ 102,911	3,392,152	$ 3,495,063
Investments, at fair value:			
Cash Management Fund	60,247,655	189,665,008	249,912,663
Total investments	60,247,655	189,665,008	249,912,663
Receivables:			
Other	1,096,798	80,076,833	81,173,631
Due from other funds	31,183,937	4,391,212	35,575,149
Total receivables	32,280,735	84,468,045	116,748,780
Total assets	$ 92,631,301	277,525,205	$ 370,156,506
Liabilities:			
Accounts payable and accrued expenses	$ 31,259,555	17,976,104	$ 49,235,659
Incurred but not reported claims	110,281,000	187,210,000	297,491,000
Deferred revenue	5,212,436	4,540,421	9,752,857
Due to other funds	257,065	1,366,006	1,623,071
Total liabilities	147,010,056	211,092,531	358,102,587
Net assets (deficit) - unrestricted	(54,378,755)	66,432,674	12,053,919
Total liabilities and net assets (deficit) -unrestricted	$ 92,631,301	277,525,205	$ 370,156,506

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 Activities

Year Ended June 30, 2003

Functions/Programs	Expenses	Program Revenues Charges for Services (Contributions)	Net (Expense) Revenue and Changes in Net Assets (Deficit) Governmental Activities	Business-Type Activities	TOTAL
Primary government:					
Governmental activities:					
Health Benefits Program - State	$ 816,181,188	815,788,562	(392,626)	—	$ (392,626)
Dental Expense Program	56,978,567	55,792,287	(1,186,280)	—	(1,186,280)
Prescription Drug Program - State	175,803,108	191,046,851	15,243,743	—	15,243,743
Total governmental activities	1,048,962,863	1,062,627,700	13,664,837	—	13,664,837
Business-type activities:					
Health Benefits Program - Local	1,304,442,508	1,420,940,613	—	116,498,105	116,498,105
Prescription Drug Program - Local	62,613,162	65,664,096	—	3,050,934	3,050,934
Total business-type activities	1,367,055,670	1,486,604,709	—	119,549,039	119,549,039
Total primary government	$ 2,416,018,533	2,549,232,409	13,664,837	119,549,039	$ 133,213,876
General Revenues :					
Investment Earnings			$ 1,157,744	1,378,803	$ 2,536,547
Total general revenues			1,157,744	1,378,803	2,536,547
Change in Net Assets			14,822,581	120,927,842	135,750,423
Net assets (deficit) - Beginning of year			(69,201,336)	(54,495,168)	(123,696,504)
Net assets (deficit) - End of year			$ (54,378,755)	66,432,674	$ 12,053,919

See accompanying notes to financial statements.

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

Balance Sheet
Governmental Funds

June 30, 2003

	HEALTH BENEFITS PROGRAM FUND STATE	DENTAL EXPENSE PROGRAM FUND	PRESCRIPTION DRUG PROGRAM FUND STATE	TOTAL
Assets:				
Cash and cash equivalents	$ 102,789	—	122	$ 102,911
Investments, at fair value:				
Cash Management Fund	17,642,381	17,792,443	24,812,831	60,247,655
Total investments	17,642,381	17,792,443	24,812,831	60,247,655
Receivables:				
Other	661,782	398,205	36,811	1,096,798
Due from other funds	23,091,939	3,502,313	4,589,685	31,183,937
Total receivables	23,753,721	3,900,518	4,626,496	32,280,735
Total assets	$ 41,498,891	21,692,961	29,439,449	$ 92,631,301
Liabilities:				
Accounts payable and accrued expenses	$ 25,031,880	1,517,675	4,710,000	$ 31,259,555
Deferred revenue	4,693,084	515,612	3,740	5,212,436
Due to other funds	182,937	—	74,128	257,065
Total liabilities	29,907,901	2,033,287	4,787,868	36,729,056
Fund Balances:				
Unreserved	11,590,990	19,659,674	24,651,581	55,902,245
Total liabilities and fund balances	$ 41,498,891	21,692,961	29,439,449	$ 92,631,301
Amounts reported in the statement of net assets are different because: Long term liabilities including IBNR are not due and payable in the current period and therefore not reported in the funds.	(106,931,000)	(3,350,000)		(110,281,000)
Fund balance (deficiencies)	$ (95,340,010)	16,309,674		$ (54,378,755)

See accompanying notes to financial statements.

STATE OF NEW JERSEY
HEALTH BENEFIT 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, 2003

	HEALTH BENEFITS PROGRAM FUND STATE	DENTAL EXPENSE PROGRAM FUND	PRESCRIPTION DRUG PROGRAM FUND STATE	TOTAL
Revenues:				
Contributions:				
Members	$ 67,800,942	29,601,504	1,135,975	$ 98,538,421
Employers	747,987,620	26,190,783	189,910,876	964,089,279
Total contributions	815,788,562	55,792,287	191,046,851	1,062,627,700
Investment income:				
Net appreciation (depreciation) in fair value of investments	(47,165)	(33,668)	(38,384)	(119,217)
Interest	630,691	363,523	282,747	1,276,961
Total investment income	583,526	329,855	244,363	1,157,744
Total revenues	816,372,088	56,122,142	191,291,214	1,063,785,444
Expenditures:				
Benefits	798,840,982	56,898,567	175,803,108	1,031,542,657
Administrative expense	2,919,206	—	—	2,919,206
Total expenditures	801,760,188	56,898,567	175,803,108	1,034,461,863
Excess (deficiency) of revenues over (under) expenditures	14,611,900	(776,425)	15,488,106	29,323,581
Other Financing Sources (Uses):				
Transfers in	—	—	3,030,000	3,030,000
Transfers out	(3,030,000)	—		(3,030,000)
Total other financing sources and uses	(3,030,000)	—	3,030,000	—
Net change in fund balances	11,581,900	(776,425)	18,518,106	29,323,581
Fund Balances:				
Beginning of year	9,090	20,436,099	6,133,475	26,578,664
End of year	$ 11,590,990	19,659,674	24,651,581	$ 55,902,245

See accompanying notes to financial statements.

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

Statement of Net Assets
Proprietary Funds

June 30, 2003

	HEALTH BENEFITS PROGRAM FUND LOCAL	PRESCRIPTION DRUG PROGRAM FUND LOCAL	TOTAL
Assets:			
Cash and cash equivalents	$ 3,338,135	54,017	$ 3,392,152
Investments, at fair value:			
Cash Management Fund	182,874,683	6,790,325	189,665,008
Total investments	182,874,683	6,790,325	189,665,008
Receivables:			
Other	72,952,113	7,124,720	80,076,833
Due from other funds	4,391,212	—	4,391,212
Total receivables	77,343,325	7,124,720	84,468,045
Total assets	$ 263,556,143	13,969,062	$ 277,525,205
Liabilities:			
Accounts payable and accrued expenses	$ 17,976,104	—	$ 17,976,104
Incurred but not reported claims	182,510,000	4,700,000	187,210,000
Deferred revenue	4,540,421	—	4,540,421
Due to other funds	416,639	949,367	1,366,006
Total liabilities	205,443,164	5,649,367	211,092,531
Net Assets	$ 58,112,979	8,319,695	$ 66,432,674

See accompanying notes to financial statements.

STATE OF NEW JERSEY
HEALTH BENEFIT 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, 2003

	HEALTH BENEFITS PROGRAM FUND LOCAL	PRESCRIPTION DRUG PROGRAM FUND LOCAL	TOTAL
Operating Revenues:			
Contributions:			
Members	$ 74,968,997	371,825	$ 75,340,822
Employers	1,345,971,616	65,292,271	1,411,263,887
Total operating revenues	1,420,940,613	65,664,096	1,486,604,709
Operating Expenses:			
Benefits	1,300,063,698	62,613,162	1,362,676,860
Administrative expense	4,378,810	—	4,378,810
Total operating expenses	1,304,442,508	62,613,162	1,367,055,670
Operating income (loss)	116,498,105	3,050,934	119,549,039
Non-operating revenue:			
Investment income:			
Net appreciation (depreciation) in fair value of investments	(32,272)	(6,774)	(39,046)
Interest	1,347,162	70,687	1,417,849
Total non-operating revenue	1,314,890	63,913	1,378,803
Change in net assets (deficit)	117,812,995	3,114,847	120,927,842
Net Assets (deficit):			
Beginning of year	(59,700,016)	5,204,848	(54,495,168)
End of year	$ 58,112,979	8,319,695	$ 66,432,674

See accompanying notes to financial statements.

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Statement of Cash Flows
Proprietary Funds

Year Ended June 30, 2003

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Cash flows from operating activities:			
Receipts - Employer Contributions	$ 1,343,967,055	62,708,972	$ 1,406,676,027
Receipts - Member Contributions	74,660,607	363,234	75,023,841
Benefit payments	(1,239,041,323)	(60,274,461)	(1,299,315,784)
Premium payments	(50,419,180)	—	(50,419,180)
Administrative expense	(4,369,731)	—	(4,369,731)
Net cash provided by operating activities	124,797,428	2,797,745	127,595,173
Cash flows from investing activities:			
Interest and dividends	1,347,162	70,687	1,417,849
Sale/purchase of investments	(126,833,748)	(2,914,966)	(129,748,714)
Net cash provided by investing activities	(125,486,586)	(2,844,279)	(128,330,865)
Decrease in cash equivalents	(689,158)	(46,534)	(735,692)
Cash and cash equivalents beginning of year	4,027,293	100,551	4,127,844
Cash and cash equivalents end of year	$ 3,338,135	54,017	$ 3,392,152
Reconciliation of operating income to net cash provided by operating activities			
Operating Income	$ 116,498,105	3,050,934	$ 119,549,039
Adjustments to reconcile operating income to net cash used by operating activities:			
Changes in assets and liabilities:			
(Increase)/decrease in accounts receivable	(1,403,035)	(2,591,890)	(3,994,925)
(Increase)/decrease in interfund receivable	(909,917)	—	(909,917)
Increase/(decrease) in accounts payable	11,151,310	1,428,783	12,580,093
Increase/(decrease) in due to other funds	(539,035)	909,918	370,883
Total adjustments	8,299,323	(253,189)	8,046,134
Net cash provided by operating activities	$ 124,797,428	2,797,745	$ 127,595,173

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, 2003

(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 Funds, which are administered by the Division over which operating controls are with the individual funds governing Boards and/or the State of New Jersey. The financial statements of the funds are included in the financial 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. Funds are classified into two categories: governmental and proprietary.

Governmental funds:

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

Proprietary funds:

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

(2) SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Measurement Focus and Basis of Accounting:

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

The focus of the government wide statements and proprietary funds measurement is upon determination of net income, financial position and cash flows. The generally accepted accounting principles applicable are those similar to businesses in the private sector. The change in IBNR claims are recognized on the full accrual basis in the government wide Statement of Activities. As a result total expenditures are $14,501,000 higher when compared to the Statement of Revenues, Expenditures, and Changes in Fund Balances of governmental funds.

Financial Reporting Model:

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

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. 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, 2003, all investments held by the Funds (other than 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 custodian 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.

New Legislation:

Chapter 3, P.L. 2003, effective January 27, 2003, amends the statutes that allow a municipality that participates in the State Health Benefit Program – or a county or a municipality that participates in another group health benefits plan – to allow an employee who is eligible for other health care coverage to waive coverage to which the employee is entitled as an employee of the county or the municipality.

Chapter 119, P.L. 2003, effective July 1, 2003, provides that a State employee enrolled in SHBP on or after July 1, 2003 may not be eligible for coverage in the traditional plan pursuant to a binding collective negotiation agreement by the State Health Benefits Commission.

Membership and Contributing Employers:

Membership in the funds administered by the Division consisted of the following as of June 30, 2003:

	STATE	LOCAL	TOTAL
Health Benefits Program Fund*	138,671	211,996	350,667
Prescription Drug Program Fund	106,391	34,948	141,339
Dental Expense Program Fund	96,911	—	96,911

* 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, 2003, which includes funding for the July 1, 2003 retirement payroll, are designated category 3.

(3) CONTRIBUTIONS

Contribution Requirements - SHBP- State and Local

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

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

Contribution Requirements - PDPF- State and Local

Contributions to pay for the premiums of participating employees in the Prescription Drug Program Fund are collected from the State of New Jersey, participating local employers, and former active and retired members who have elected to participate under the rules of COBRA. The State of New Jersey provides contributions for State employees through State appropriations. These appropriations are distributed to the 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 Expense Program Fund 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 DEPF 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 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 ($11,590,990); PDPF - State ($24,651,581); and DEPF ($19,659,674)

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.

Reserve Fund - SHBP - Local ($58,112,979); PDPF - Local ($8,319,695)

The SHBP - local has net assets of $58,112,979 as of June 30, 2003. The deficit of the prior fiscal year was made up by a rate action.

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

(6) UNPAID CLAIMS LIABILITIES

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

	HEALTH BENEFITS PROGRAM FUND LOCAL	PRESCRIPT DRUG PROGRA FUND LOCAL
Unpaid claims at beginning of year	$ 194,423,330	$ 3,250,0(
Incurred claims:		
Provision for insured events of current year	1,300,063,699	62,613,1(
Payments	(1,294,000,925)	(61,163,1(
Unpaid claims at end of year	$ 200,486,104	$ 4,700,0(

Schedule 1

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

Loss Development Information

June 30, 2003

HEALTH BENEFITS PROGRAM FUND - LOCAL	**FISCAL YEAR ENDED JUNE 30 2003**
Premiums and investment revenue Earned	1,422,255,503
Estimated expenses	1,304,442,508

PRESCRIPTION DRUG PROGRAM FUND - LOCAL	**FISCAL YEAR ENDED JUNE 30 2003**
Premiums and investment revenue Earned	65,664,096
Estimated expenses	62,613,162

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 State Health Benefits Program.

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

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

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

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

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

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

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

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

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

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

retirement benefits. This law was effective March 8, 1990.

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

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

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

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

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

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

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

retire (except for deferred retirements).

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

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

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

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

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

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

Chapter 44, P.L. 1998 abolishes the Department of Commerce and Economic Development and creates the New Jersey Commerce and Economic Growth Commission. Section 7 of the bill states that employees of the commission shall be enrolled in the Public Employees' Retirement System and shall be eligible to participate in the State Health Benefits Program. The Commission can, however, elect to provide health benefits for its employees through private insurance policies, hospital and medical service corporations,

HMOs, or any other manner available for the provision of health benefits, provided that the types of benefits do not provide less coverage than those benefits provided to other State employees.

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

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

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

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

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

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

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

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

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

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

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

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

ties, municipalities and school districts. It also resolves certain administrative ambiguities and encourages more business-like practices on the part of local units in order to effectuate cost savings that will benefit property taxpayers. It is an omnibus piece of legislation, much of which is not related to pension or health benefit coverage.

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

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

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

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

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

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

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

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

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

The law applies to any health insurance carrier, multiple employer welfare arrangement or other health benefits plan provider, its agents (including any pharmacy benefits manager or third party administrator

for a self-insured health benefits plan), that provides, administers or manages coverage for prescription drugs provided on an outpatient basis. The law explicitly does not apply to providers of Medicaid fee for service, Medicare supplemental insurance, disability income and long-term care plans, hospital indemnity insurance, and various other plans offering restricted health benefit coverage.

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

(1) the insured's identification number;

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

(3) if required for proper claims adjudication,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

STATE MONTHLY ACTIVE GROUP

RATES EFFECTIVE 1/1/2003 TO 12/31/2003

	DESCRIPTION OF COVERAGE	STATE CONTRIBUTION	MAXIMUM EMPLOYEE CONTRIBUTION	TOTAL
NJ PLUS-#001	Single	$255.11	—	$255.11
	Member & Spouse	$556.04	—	$556.04
	Family	$661.83	—	$661.83
	Parent & Child	$383.79	—	$383.79
TRADITIONAL-#002	Single	$329.43	$109.81	$439.24
	Member & Spouse	$705.08	$235.02	$940.10
	Family	$839.16	$279.72	$1,118.88
	Parent & Child	$486.59	$162.19	$648.78
AETNA HEALTH-#019	Single	$252.48	$13.28	$265.76
	Member & Spouse	$557.72	$29.35	$587.07
	Family	$648.69	$34.14	$682.83
	Parent & Child	$373.53	$19.65	$393.18
CIGNA HEALTHCARE-#020	Single	$286.44	$15.07	$301.51
	Member & Spouse	$624.76	$32.88	$657.64
	Family	$745.15	$39.21	$784.36
	Parent & Child	$429.95	$22.62	$452.57
OXFORD-#028	Single	$248.32	$13.06	$261.38
	Member & Spouse	$546.19	$28.74	$574.93
	Family	$645.51	$33.97	$679.48
	Parent & Child	$372.47	$19.60	$392.07
AMERIHEALTH-#033	Single	$276.98	$14.57	$291.55
	Member & Spouse	$616.18	$32.43	$648.61
	Family	$717.62	$37.76	$755.38
	Parent & Child	$408.85	$21.51	$430.36
HEALTH NET-#034	Single	$247.88	$13.04	$260.92
	Member & Spouse	$539.93	$28.41	$568.34
	Family	$655.41	$34.49	$689.90
	Parent & Child	$380.22	$20.01	$400.23
PRESCRIPTION DRUG PROGRAM-#201	Single	$89.04	—	$89.04
	Member & Spouse	$203.51	—	$203.51
	Family	$213.75	—	$213.75
	Parent & Child	$118.84	—	$118.84

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

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

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

LOCAL MONTHLY ACTIVE GROUP - EDUCATION EMPLOYERS

RATES EFFECTIVE 1/1/2003 TO 12/31/2003

PROGRAM	DESCRIPTION OF COVERAGE	EMPLOYER SINGLE COST	DEPENDENT COST	TOTAL
NJ PLUS-#001	Single	$283.18	—	$283.18
	Member & Spouse	$284.62	$345.64	$630.26
	Family	$285.15	$448.15	$733.30
	Parent & Child	$283.81	$134.34	$418.15
TRADITIONAL-#002	Single	$398.27	—	$398.27
	Member & Spouse	$399.71	$464.86	$864.57
	Family	$400.24	$611.50	$1,011.74
	Parent & Child	$398.90	$180.57	$579.47
AETNA, INC.-#019	Single	$371.70	—	$371.70
	Member & Spouse	$373.14	$431.42	$804.56
	Family	$373.67	$532.22	$905.89
	Parent & Child	$372.33	$138.76	$511.09
CIGNA HEALTHCARE-#020	Single	$401.69	—	$401.69
	Member & Spouse	$403.13	$458.90	$862.03
	Family	$403.66	$587.87	$991.53
	Parent & Child	$402.32	$158.76	$561.08
OXFORD-#028	Single	$314.87	—	$314.87
	Member & Spouse	$316.31	$376.27	$692.58
	Family	$316.84	$501.70	$818.54
	Parent & Child	$315.50	$156.78	$472.28
AMERIHEALTH-#033	Single	$382.71	—	$382.71
	Member & Spouse	$384.15	$467.29	$851.44
	Family	$384.68	$606.89	$991.57
	Parent & Child	$383.34	$181.57	$564.91
HEALTH NET-#034	Single	$350.58	—	$350.58
	Member & Spouse	$352.02	$411.66	$763.68
	Family	$352.55	$574.49	$927.04
	Parent & Child	$351.21	$186.60	$537.81

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

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

LOCAL MONTHLY ACTIVE GROUP - EDUCATION EMPLOYERS

RATES EFFECTIVE 1/1/2003 TO 12/31/2003

PROGRAM	DESCRIPTION OF COVERAGE	EMPLOYER SINGLE COST	DEPENDENT COST	TOTAL
NJ PLUS-#001	Single	$254.25	—	$254.25
	Member & Spouse	$255.69	$310.17	$565.86
	Family	$256.22	$402.17	$658.39
	Parent & Child	$254.88	$120.55	$375.43
TRADITIONAL-#002	Single	$339.64	—	$339.64
	Member & Spouse	$341.08	$399.68	$740.76
	Family	$341.61	$524.28	$865.89
	Parent & Child	$340.27	$155.23	$495.50
AETNA, INC.-#019	Single	$273.69	—	$273.69
	Member & Spouse	$275.13	$329.47	$604.60
	Family	$275.66	$427.56	$703.22
	Parent & Child	$274.32	$130.60	$404.92
CIGNA HEALTHCARE-#020	Single	$301.51	—	$301.51
	Member & Spouse	$302.95	$354.69	$657.64
	Family	$303.48	$480.88	$784.36
	Parent & Child	$302.14	$150.43	$452.57
OXFORD-#028	Single	$261.38	—	$261.38
	Member & Spouse	$262.82	$312.11	$574.93
	Family	$263.35	$416.13	$679.48
	Parent & Child	$262.01	$130.06	$392.07
AMERIHEALTH-#033	Single	$291.55	—	$291.55
	Member & Spouse	$292.99	$355.62	$648.61
	Family	$293.52	$461.86	$755.38
	Parent & Child	$292.18	$138.18	$430.36
HEALTH NET-#034	Single	$260.92	—	$260.92
	Member & Spouse	$262.36	$305.98	$568.34
	Family	$262.89	$427.01	$689.90
	Parent & Child	$261.55	$138.68	$400.23
PRESCRIPTION DRUG PROGRAM-#201	Single	$92.71	—	$92.71
	Member & Spouse	$92.71	$119.21	$211.92
	Family	$92.71	$130.12	$222.83
	Parent & Child	$92.71	$31.06	$123.77

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

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

LOCAL MONTHLY ACTIVE GROUP - (EXCLUDES EDUCATION EMPLOYERS)

RATES EFFECTIVE 1/1/2003 TO 12/31/2003

PROGRAM	DESCRIPTION OF COVERAGE	EMPLOYER SINGLE COST	DEPENDENT COST	TOTAL
NJ PLUS-#001	Single	$313.46	—	$313.46
	Member & Spouse	$314.90	$382.74	$697.64
	Family	$315.43	$496.29	$811.72
	Parent & Child	$314.09	$148.77	$462.86
TRADITIONAL-#002	Single	$413.32	—	$413.32
	Member & Spouse	$414.76	$482.52	$897.28
	Family	$415.29	$634.75	$1,050.04
	Parent & Child	$413.95	$187.42	$601.37
AETNA, INC.-#019	Single	$371.70	—	$371.70
	Member & Spouse	$373.14	$431.42	$804.56
	Family	$373.67	$532.22	$905.89
	Parent & Child	$372.33	$138.76	$511.09
CIGNA HEALTHCARE-#020	Single	$401.69	—	$401.69
	Member & Spouse	$403.13	$458.90	$862.03
	Family	$403.66	$587.87	$991.53
	Parent & Child	$402.32	$158.76	$561.08
OXFORD-#028	Single	$314.87	—	$314.87
	Member & Spouse	$316.31	$376.27	$692.58
	Family	$316.84	$501.70	$818.54
	Parent & Child	$315.50	$156.78	$472.28
AMERIHEALTH-#033	Single	$382.71	—	$382.71
	Member & Spouse	$384.15	$467.29	$851.44
	Family	$384.68	$606.89	$991.57
	Parent & Child	$383.34	$181.57	$564.91
HEALTH NET-#034	Single	$350.58	—	$350.58
	Member & Spouse	$352.02	$411.66	$763.68
	Family	$352.55	$574.49	$927.04
	Parent & Child	$351.21	$186.60	$537.81

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

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

LOCAL MONTHLY ACTIVE GROUP - (EXCLUDES EDUCATION EMPLOYERS)

RATES EFFECTIVE 1/1/2003 TO 12/31/2003

PROGRAM	DESCRIPTION OF COVERAGE	EMPLOYER SINGLE COST	DEPENDENT COST	TOTAL
NJ PLUS-#001	Single	$290.41	—	$290.41
	Member & Spouse	$291.85	$354.53	$646.38
	Family	$292.38	$459.70	$752.08
	Parent & Child	$291.04	$137.79	$428.83
TRADITIONAL-#002	Single	$368.47	—	$368.47
	Member & Spouse	$369.91	$433.75	$803.66
	Family	$370.44	$568.98	$939.42
	Parent & Child	$369.10	$168.49	$537.59
AETNA, INC.-#019	Single	$273.69	—	$273.69
	Member & Spouse	$275.13	$329.47	$604.60
	Family	$275.66	$427.56	$703.22
	Parent & Child	$274.32	$130.60	$404.92
CIGNA HEALTHCARE-#020	Single	$301.51	—	$301.51
	Member & Spouse	$302.95	$354.69	$657.64
	Family	$303.48	$480.88	$784.36
	Parent & Child	$302.14	$150.43	$452.57
OXFORD-#028	Single	$261.38	—	$261.38
	Member & Spouse	$262.82	$312.11	$574.93
	Family	$263.35	$416.13	$679.48
	Parent & Child	$262.01	$130.06	$392.07
AMERIHEALTH-#033	Single	$291.55	—	$291.55
	Member & Spouse	$292.99	$355.62	$648.61
	Family	$293.52	$461.86	$755.38
	Parent & Child	$292.18	$138.18	$430.36
HEALTH NET-#034	Single	$260.92	—	$260.92
	Member & Spouse	$262.36	$305.98	$568.34
	Family	$262.89	$427.01	$689.90
	Parent & Child	$261.55	$138.68	$400.23
PRESCRIPTION DRUG PROGRAM-#201	Single	$92.71	—	$92.71
	Member & Spouse	$92.71	$119.21	$211.92
	Family	$92.71	$130.12	$222.83
	Parent & Child	$92.71	$31.06	$123.77

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

DENTAL PROGRAM

MONTHLY GROUP RATES EFFECTIVE 1/1/2003 TO 12/31/2003

	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)				
HEALTHPLEX (DPO #307) FORTIS (DPO #308) FLAGSHIP HEALTH SYSTEMS, INC. (DPO #312) HORIZON DENTAL CHOICE (DPO #317)	SINGLE	$8.94	$8.84	$17.78
	MEMBER & SPOUSE	$15.45	$15.45	$30.90
	FAMILY	$25.37	$25.19	$50.56
	PARENT & CHILD	$18.90	$18.56	$37.46
BENECARE (DPO #301)	SINGLE	$12.09	$8.84	$20.93
	MEMBER & SPOUSE	$20.92	$15.45	$36.37
	FAMILY	$34.32	$25.19	$59.51
	PARENT & CHILD	$25.53	$18.56	$44.09
COMMUNITY DENTAL (DPO #302)	SINGLE	$11.14	$8.84	$19.98
	MEMBER & SPOUSE	$19.27	$15.45	$34.72
	FAMILY	$31.62	$25.19	$56.81
	PARENT & CHILD	$23.52	$18.56	$42.08
CIGNA (DPO #305)	SINGLE	$9.38	$8.84	$18.22
	MEMBER & SPOUSE	$16.23	$15.45	$31.68
	FAMILY	$26.63	$25.19	$51.82
	PARENT & CHILD	$19.84	$18.56	$38.40
GROUP DENTAL HEALTH ADMINISTRATORS (DPO #306)	SINGLE	$9.28	$8.84	$18.12
	MEMBER & SPOUSE	$16.04	$15.45	$31.49
	FAMILY	$26.33	$25.19	$51.52
	PARENT & CHILD	$19.62	$18.56	$38.18
UNITY (DPO #311)	SINGLE	$8.04	$8.84	$16.88
	MEMBER & SPOUSE	$13.91	$15.45	$29.36
	FAMILY	$22.84	$25.19	$48.03
	PARENT & CHILD	$17.04	$18.56	$35.60
DENTAL GROUP OF NEW JERSEY, INC. (DPO#314)	SINGLE	$7.78	$8.84	$16.62
	MEMBER & SPOUSE	$13.45	$15.45	$28.90
	FAMILY	$22.08	$25.19	$47.27
	PARENT & CHILD	$16.47	$18.56	$35.03
AETNA DMO (DPO #319)	SINGLE	$7.78	$8.84	$16.62
	MEMBER & SPOUSE	$13.45	$15.45	$28.90
	FAMILY	$22.08	$25.19	$47.27
	PARENT & CHILD	$16.47	$18.56	$35.03

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