

NEW JERSEY
STATE HEALTH BENEFITS PROGRAM
AND
SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM

***PRESCRIPTION DRUG
PLANS
MEMBER HANDBOOK***



**Department of the Treasury
Division of Pensions and Benefits**

Plan Year 2013

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INTRODUCTION

The State Health Benefits Program (SHBP) was established in 1961. It offers medical and prescription drug coverage to qualified State and local government public employees, retirees, and eligible dependents; and dental coverage to qualified State and local government/education public employees, retirees, and their eligible dependents. Local employers must adopt a resolution to participate in the SHBP.

The State Health Benefits Commission (SHBC) is the executive organization responsible for overseeing the SHBP.

The State Health Benefits Program Act is found in the New Jersey Statutes Annotated, Title 52, Article 14-17.25 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

The School Employees' Health Benefits Program (SEHBP) was established in 2007. It offers medical and prescription drug coverage to qualified local education public employees, retirees, and eligible dependents. Local education employers must adopt a resolution to participate in the SEHBP.

The School Employees' Health Benefits Commission (SEHBC) is the executive organization responsible for overseeing the SEHBP.

The School Employees' Health Benefits Program Act is found in the New Jersey Statutes Annotated, Title 52, Article 14-17.46 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

The Division of Pensions and Benefits, specifically the Health Benefits Bureau and the Bureau of Policy and Planning, are responsible for the daily administrative activities of the SHBP and the SEHBP.

The Prescription Drug Plans are administered for the SHBP and SEHBP by Express Scripts (formerly Medco), the pharmacy benefit manager for all eligible members. Prescription drugs are available at designated copayment levels only when a participating licensed pharmacy is used. A prescription drug plan identification card is provided and use of the ID card is required to obtain medications at a participating retail pharmacy for the designated copayment.

Every effort has been made to ensure the accuracy of the *Prescription Drug Plans Member Handbook*. However, State law and the New Jersey Administrative Code govern the SHBP and SEHBP. If there are discrepancies between the information presented in this booklet and/or plan documents and the law, regulations, or contracts, the law, regulations, and contracts will govern. Furthermore, if you are unsure whether a drug is covered, contact Express Scripts before you receive services to avoid any denial of coverage issues that could result.

If, after reading this booklet, you have any questions, comments, or suggestions regarding the information presented, please write to the Division of Pensions and Benefits, PO Box 295, Trenton, NJ 08625-0295, call us at (609) 292-7524, or send e-mail to: pensions.nj@treas.state.nj.us



STATE HEALTH BENEFITS PROGRAM
AND
SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM

PRESCRIPTION DRUG PLANS

ELIGIBILITY

The Prescription Drug Plans' rules of eligibility and information on maintaining coverage are the same as those for the State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) medical plans. Please refer to the *Summary Program Description* for additional eligibility, enrollment, and coverage information (see page 40 for information on how to obtain this publication). The only exception is employees of Local Employers who have chosen a private prescription drug plan for their employees rather than one of the SHBP/SEHBP prescription drug plans. If your Local Employer has chosen a private prescription drug plan it must be substantially similar to the prescription drug plans offered by the SHBP/SEHBP.

NOTE: In the past regardless of which medical plan you were enrolled, under the Employee Prescription Drug Plan, your copayments for prescription drugs were the same. As a result of the SHBP/SEHBP Plan Design Committees' actions, the copayments for prescription drugs are now determined by the medical plan you select.

PLAN BENEFITS

The prescription drug plans are administered for the SHBP and SEHBP by Express Scripts, formerly Medco, and can be obtained through a participating pharmacy, through the Medco Pharmacy™, mail order, or through Accredo, Express Scripts' specialty pharmacy service. A prescription drug plan identification card is provided and use of the ID card is required to obtain medications at a participating retail pharmacy for the designated copayment/coinsurance.

RETAIL PHARMACY

Normally, retail pharmacy copayment amounts are for a 30-day supply. However, you may obtain up to a 90-day supply of your prescription drug. To do so, you must pay two copayments for a 31 to 60-day supply or three copayments for a 61 to 90-day supply (see page 3 for copayment information). Additional information about purchasing prescription drugs at a retail pharmacy begins on page 9.

MAIL ORDER SERVICE

Mail order benefits are available where participants can receive up to a 90-day supply of prescription drugs for one copayment (see page 3 for copayment information). Additional information about using the mail order service begins on page 11.

SPECIALTY PHARMACEUTICAL PROVIDER

Specialty pharmaceuticals are provided through Accredo (Express Scripts specialty pharmacy), which is the exclusive provider for specialty pharmaceuticals for the Employee Prescription Drug Plans.

If your doctor has prescribed a specialty pharmaceutical, you will not be able to fill the prescription at a retail pharmacy. Instead, you should contact Accredo at 1-800-501-7260. When calling, identify yourself as a SHBP or SEHBP member. Accredo will contact your doctor for the prescription and will work with you to arrange a convenient delivery location and date. Your medication will be shipped directly to your home, office, or doctor's office, via United Parcel Service (UPS).

Your mail order service copayment will apply for all specialty prescriptions; keep in mind some medications will not or cannot be dispensed in a 90 day supply.

COPAYMENT/COINSURANCE* AMOUNTS

EMPLOYEE PRESCRIPTION DRUG COVERAGE

State Employees

The amount that State employees and their eligible dependents pay for prescription drugs is determined by the medical plan the employee selects.

Note: In the past, regardless of which medical plan you were enrolled, the Employee Prescription Drug Plan copayments were the same. As a result of the SHBP/SEHBP Plan Design Committees' actions, the copayments for prescription drugs are now determined by the medical plan you select.

The State Health Benefit Plan Design Committee establishes the copayment amounts on an annual basis. In Plan Year 2013 a State employee or dependent will pay the following copayment amounts:

- If enrolled in Aetna Freedom15, NJ DIRECT15, Aetna HMO, or Horizon HMO, the copayment at a retail pharmacy for up to a 30-day supply is \$3 for generic drugs; \$10 for brand name drugs without generic equivalents; and \$25 for brand name drugs with generic equivalents. The mail order copayment pharmacy for up to a 90-day supply is \$5 for generic drugs; \$15 for brand name drugs without generic equivalents; and \$40 for brand name drugs with generic equivalents.
- If enrolled in Aetna Freedom1525, NJ DIRECT1525, Aetna HMO1525, or Horizon HMO1525, the copayment at a retail pharmacy for up to a 30-day supply is \$7 for generic drugs; \$16 for brand name drugs without generic equivalents; and \$35 for brand name drugs with generic equivalents. The mail order copayment for up to a 90-day supply is \$18 for generic drugs; \$40 for brand name drugs without generic equivalents; and \$88 for brand name drugs with generic equivalents.

**Copayments apply to most of the plans with the exceptions of the NJ DIRECT Prescription Drug Plan and the High Deductible Health Plans (HDHP) in which coinsurance applies.*

- If enrolled in Aetna Freedom2030, NJ DIRECT2030, Aetna HMO2030, or Horizon HMO2030, the copayment at a retail pharmacy for up to a 30-day supply is \$3 for generic drugs; \$18 for brand name drugs without generic equivalents; and \$46 for brand name drugs with generic equivalents. The mail order copayment for up to a 90-day supply is \$5 for generic drugs; \$36 for brand name drugs without generic equivalents; and \$92 for brand name drugs with generic equivalents.
- If enrolled in Aetna Value HD1500, NJ DIRECT HD1500, Aetna Value HD4000, or NJ DIRECT HD4000, the prescription drugs are included in the plan and are subject to a deductible and coinsurance. This means that the member pays the full cost of the medications until the deductible is reached. Once the deductible is reached, the member pays the applicable coinsurance until the out-of-pocket maximum is met.

Local Government and Local Education Employees

The amount that local government/education employees and their eligible dependents pay for prescription drugs is determined by the prescription drug plan option provided by the employer and the medical plan the employee selects.

Local government and local education employers may elect one of the following three options to provide prescription drug benefits to their employees:

1. The **Employee Prescription Drug Plan**: The State Health Benefit and School Employees' Health Benefit Plan Design Committees establish the copayment amounts on an annual basis.

In Plan Year 2013 a local government/education employee or dependent will pay the following copayment amounts:

- If enrolled in Aetna Freedom10, NJ DIRECT10, Aetna Freedom15, NJ DIRECT15, Aetna HMO, or Horizon HMO, the copayment at a retail pharmacy for up to a 30-day supply is \$3 for generic drugs; and \$10 for brand name drugs. The mail order copayment for up to a 90-day supply is \$5 for generic drugs; and \$15 for brand name drugs.
- If enrolled in Aetna Freedom1525, NJ DIRECT1525, Aetna HMO1525, or Horizon HMO1525, the copayment at a retail pharmacy for up to a 30-day supply is \$7 for generic drugs; \$16 for preferred brand name drugs; and \$35 for non-preferred brand name drugs. The mail order copayment for up to a 90-day supply is \$18 for generic drugs; \$40 for preferred brand name drugs; and \$88 for non-preferred brand name drugs.
- If enrolled in Aetna Freedom2030, NJ DIRECT2030, Aetna HMO2030, or Horizon HMO2030, the copayment at a retail pharmacy for up to a 30-day supply is \$3 for generic drugs; \$18 for preferred brand name drugs; and \$46 for non-preferred brand name drugs. The mail order copayment for up to a 90-day supply is \$5 for generic drugs; \$36 for preferred brand name drugs; and \$92 for non-preferred brand name drugs.

- If enrolled in Aetna Value HD1500, NJ DIRECT HD1500, Aetna Value HD4000*, or NJ DIRECT HD4000*, the prescription drugs are included in the plan and are subject to a deductible and coinsurance. This means that the member pays the full cost of the medications until the deductible is reached. Once the deductible is reached, the member pays the applicable coinsurance until the out-of-pocket maximum is met.

*Local education employees are not eligible for any of the HD4000 plans.

2. The NJ DIRECT Prescription Drug Plan, Aetna Freedom Prescription Drug Plan, and HMO Prescription Drug Plan:

The NJ DIRECT Prescription Drug Plan is available to local government and local education employees enrolled in NJ DIRECT10, NJ DIRECT15, NJ DIRECT1525, or NJ DIRECT2030, when the local public employer does not provide either the Employee Prescription Drug Plan or a private prescription drug plan. Plan benefits are available at a discounted price (eligible pharmacy price) through participating **retail pharmacies**, through **mail order**, and through **specialty pharmacy services**.

- Members pay a coinsurance equal to 10 percent of the eligible pharmacy price when obtained through a participating retail pharmacy if you are enrolled in NJ DIRECT10 or NJ DIRECT15 and 15 percent of the eligible pharmacy price when obtained through a participating retail pharmacy if you are enrolled in NJ DIRECT1525 or NJ DIRECT2030.
- Prescription drugs are reimbursed at 80 percent of the eligible pharmacy price if you are enrolled in NJ DIRECT10, 70 percent of the eligible pharmacy price if you are enrolled in NJ DIRECT15, NJ DIRECT1525 or NJ DIRECT2030 when obtained through a non-participating retail pharmacy. There is \$100 deductible when using an out of network pharmacy (\$200 for NJ DIRECT2030).
- Prescription drugs at a discounted price are available by mail order through Express Scripts mail order or online at: www.medco.com/statenj
- Specialty pharmacy services also apply and are provided through Accredo, Express Scripts' specialty pharmacy.
- Horizon Blue Cross Blue Shield of New Jersey administers claim processing for the NJ DIRECT Prescription Drug Plan in coordination with Express Scripts.

The Aetna Freedom Prescription Drug Plan is available to local government and local education employees enrolled in Aetna Freedom10, Aetna Freedom15, Aetna Freedom1525, or Aetna Freedom2030, when the local public employer does not provide either the Employee Prescription Drug Plan or a private prescription drug plan. Plan benefits are available through participating **retail pharmacies**, by **mail order** through Express Scripts, or online at: www.medco.com/statenj and from **specialty pharmacy services** provided through Accredo, Express Scripts' specialty pharmacy.

The Aetna Freedom Prescription Drug Plan features a three-tier copayment design.

- If enrolled in Aetna Freedom10 or Aetna Freedom15, the copayment at a retail pharmacy for up to a 30-day supply is \$5 for generic drugs; \$10 for preferred brand name drugs; and \$20 for non-preferred brand name drugs. The mail order copayment for up to a 90-day supply is \$5 for generic drugs; \$15 for preferred brand name drugs; and \$25 for non-preferred brand name drugs. Specialty pharmacy services also apply.
- If enrolled in Aetna Freedom1525, the copayment at a retail pharmacy for up to a 30-day supply is \$7 for generic drugs; \$16 for preferred brand name drugs; and \$35 for non-preferred brand name drugs. The mail order copayment for up to a 90-day supply is \$18 for generic drugs; \$40 for preferred brand name drugs; and \$88 for non-preferred brand name drugs. Specialty pharmacy services also apply.
- If enrolled in Aetna Freedom2030, the copayment at a retail pharmacy for up to a 30-day supply is \$3 for generic drugs; \$18 for preferred brand name drugs; and \$48 for non-preferred brand name drugs. The mail order copayment for up to a 90-day supply is \$5 for generic drugs; \$36 for preferred brand name drugs; and \$92 for non-preferred brand name drugs. Specialty pharmacy services also apply.

The HMO Prescription Drug Plan is available to local government and local education employees enrolled in Aetna HMO, Horizon HMO, Aetna HMO1525, Horizon HMO1525, Aetna HMO2030, or Horizon HMO2030, when the local public employer does not provide either the Employee Prescription Drug Plan or a private prescription drug plan. Plan benefits are available through participating **retail pharmacies**, by **mail order** through Express Scripts, or online at: www.medco.com/statenj and from **specialty pharmacy services** provided through Accredo, Express Scripts' specialty pharmacy.

The HMO Prescription Drug Plan features a three-tier copayment design for prescription drugs that are prescribed by your Primary Care Physician (PCP) or a provider to whom your PCP has referred you.

- If enrolled in Aetna HMO or Horizon HMO, the copayment at a retail pharmacy for up to a 30-day supply is \$5 for generic drugs; \$10 for preferred brand name drugs; and \$20 for non-preferred brand name drugs. The mail order copayment for up to a 90-day supply, if authorized by your PCP, is \$5 for generic drugs; \$15 for preferred brand name drugs; and \$25 for non-preferred brand name drugs. Specialty pharmacy services also apply.
- If enrolled in Aetna HMO1525 or Horizon HMO1525, the copayment at a retail pharmacy for up to a 30-day supply is \$7 for generic drugs; \$16 for preferred brand name drugs; and \$35 for non-preferred brand name drugs. The mail order copayment for up to a 90-day supply, if authorized by your PCP, is \$18 for generic drugs; \$40 for preferred brand name drugs; and \$88 for non-preferred brand name drugs. Specialty pharmacy services also apply.
- If enrolled in Aetna HMO2030 or Horizon HMO2030, the copayment at a retail pharmacy for up to a 30-day supply is \$3 for generic drugs; \$18 for preferred brand name drugs; and \$48 for non-preferred brand name drugs. The mail order copayment for up to a 90-day supply, if authorized by your PCP, is \$5 for generic drugs; \$36 for preferred brand name drugs; and \$92 for non-preferred brand name drugs. Specialty pharmacy services also apply.

High Deductible Health Plans (HDHP): If enrolled in Aetna Value HD1500, NJ DIRECT HD1500, Aetna Value HD4000*, or NJ DIRECT HD4000*, the prescription drugs are included in the plan and are subject to a deductible and coinsurance. This means that the member pays the full cost of the medications until the deductible is reached. Once the deductible is reached, the member pays the applicable coinsurance until the out-of-pocket maximum is met.

**Local education employees are not eligible for any of the HD4000 plans.*

- 3. A private (non-SHBP/SEHBP) prescription drug plan** that is at least equal to the Employee Prescription Drug Plans.

RETIREE PRESCRIPTION DRUG COVERAGE

Retirees enrolled in a SHBP or SEHBP medical plan have access to the Retiree Prescription Drug Plan. Plan benefits are available through participating **retail pharmacies**, through **mail order**, and through **specialty pharmacy services**. The plan features a three-tier copayment design except for high deductible health plans. The copayment that retired members and their eligible dependents pay for prescription drugs is determined by the medical plan the retiree selects. **Retail pharmacy** services require a copayment for up to a 30-day supply of prescription drugs. **Mail order** participants can receive up to a 90-day supply of prescription drugs for one mail order copayment. **Specialty pharmacy services** are provided via mail through Accredo, Express Scripts specialty pharmacy. If your doctor has prescribed a specialty pharmaceutical, you will not be able to fill the prescription at a retail pharmacy.

Medicare Part D

If you are enrolled in the Retired Group of the SHBP/SEHBP and eligible for Medicare, you will be automatically enrolled in the **Express Scripts Medicare™ Prescription Drug Plan**, (PDP) formerly Medco Medicare Prescription Plan, a Medicare Part D plan.

Important: If you decide not to be enrolled in the Express Scripts Medicare™ (PDP), you will lose your prescription drug benefits provided by the SEHBP/SHBP. However, your medical benefits will continue. In order to waive the Express Scripts Medicare™ (PDP) plan you must enroll in another Medicare Part D plan. To request that you not be enrolled, you must submit a *Retired Change of Status Application* waiving your prescription drug coverage.

If you have waived your prescription drug coverage for another Medicare Part D plan, and you wish to re-enroll in the Express Scripts Medicare PDP, you must send proof of your termination from the other Medicare Part D plan. Acceptable proof is a letter confirming the date upon which you are disenrolled from the other Medicare Part D plan. We must receive this proof within 60 days of the termination from the other Medicare part D plan

Effective January 1, 2013, copayment amounts for retiree prescription drug coverage are as follows.

State Retirees and Local Government Retirees

- If enrolled in Aetna Freedom10, NJ DIRECT10, Aetna Freedom15, or NJ DIRECT15, the copayment at a retail pharmacy for up to a 30-day supply is \$11 for generic drugs; \$23 for preferred brand name drugs; and \$46 for non-preferred brand name drugs. The mail order (or specialty pharmaceutical) copayment for up

to a 90-day supply is \$11 for generic drugs; \$34 for preferred brand name drugs; and \$57 for non-preferred brand name drugs. The annual out-of-pocket maximum is \$1,355 per person.

- If enrolled in Aetna HMO/Aetna Medicare Open or Horizon HMO, the copayment at a retail pharmacy for up to a 30-day supply is \$6 for generic drugs; \$13 for preferred brand name drugs; and \$25 for non-preferred brand name drugs. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$6 for generic drugs; \$19 for preferred brand name drugs; and \$31 for non-preferred brand name drugs. The annual out-of-pocket maximum is \$1,355 per person.
- If enrolled in Aetna Freedom1525*, NJ DIRECT1525, Aetna HMO1525, or Horizon HMO1525, the copayment at a retail pharmacy for up to a 30-day supply is \$7 for generic drugs; \$16 for preferred brand name drugs; and \$35 for non-preferred brand name drugs. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$7 for generic drugs; \$40 for preferred brand name drugs; and \$88 for non-preferred brand name drugs. There is no out-of-pocket maximum.

**Medicare eligible retirees cannot enroll in Aetna Freedom1525.*

- If enrolled in Aetna Freedom2030*, NJ DIRECT2030, Aetna HMO2030*, or Horizon HMO2030, the copayment at a retail pharmacy for up to a 30-day supply is \$3 for generic drugs; \$18 for preferred brand name drugs; and \$46 for non-preferred brand name drugs. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$5 for generic drugs; \$36 for preferred brand name drugs; and \$92 for non-preferred brand name drugs. There is no out-of-pocket maximum.

**Medicare eligible retirees cannot enroll in Aetna HMO2030 or Aetna Freedom2030.*

- If enrolled in one of the High Deductible Health Plans**, Aetna Value HD4000 or NJ DIRECT 4000, the prescription drugs are included in the medical plan and are subject to a deductible and coinsurance. This means that the member pays the full cost of the medications until the deductible is reached. Once the deductible is reached, the member pays the applicable coinsurance until the out-of-pocket maximum is met.

***Medicare eligible retirees cannot enroll a High Deductible Health Plan.*

Local Education Retirees

- If enrolled in Aetna Freedom10, NJ DIRECT10, Aetna Freedom15, or NJ DIRECT15, the copayment at a retail pharmacy for up to a 30-day supply is \$10 for generic drugs; \$20 for preferred brand name drugs; and \$40 for non-preferred brand name drugs. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$5 for generic drugs; \$30 for preferred brand name drugs; and \$50 for non-preferred brand name drugs. The annual out-of-pocket maximum is \$1,322 per person.
- If enrolled in Aetna HMO/Aetna Medicare Open or Horizon HMO, the copayment at a retail pharmacy for up to a 30-day supply is \$6 for generic drugs; \$12 for preferred brand name drugs; and \$25 for non-preferred brand name drugs. The mail

order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$5 for generic drugs; \$18 for preferred brand name drugs; and \$30 for non-preferred brand name drugs. The annual out-of-pocket maximum is \$1,322 per person.

- If enrolled in Aetna Freedom1525*, NJ DIRECT1525, Aetna HMO1525, or Horizon HMO1525, the copayment at a retail pharmacy for up to a 30-day supply is \$7 for generic drugs; \$16 for preferred brand name drugs; and \$35 for non-preferred brand name drugs. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$5 for generic drugs; \$40 for preferred brand name drugs; and \$88 for non-preferred brand name drugs. The annual out-of-pocket maximum is \$1,322 per person.

**Medicare eligible retirees cannot enroll in Aetna Freedom1525.*

- If enrolled in Aetna Freedom2030*, NJ DIRECT2030, Aetna HMO2030, or Horizon HMO2030, the copayment at a retail pharmacy for up to a 30-day supply is \$3 for generic drugs; \$18 for preferred brand name drugs; and \$46 for non-preferred brand name drugs. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$5 for generic drugs; \$36 for preferred brand name drugs; and \$92 for non-preferred brand name drugs. The annual out-of-pocket maximum is \$1,322 per person.

**Medicare eligible retirees cannot enroll in Aetna Freedom2030, or Aetna Freedom HMO2030.*

- If enrolled in one of the High Deductible Health Plans**, Aetna Value HD4000 or NJ DIRECT4000, the prescription drugs are included in the medical plan and are subject to a deductible and coinsurance. This means that the member pays the full cost of the medications until the deductible is reached. Once the deductible is reached, the member pays the applicable coinsurance until the out-of-pocket maximum is met.

***Medicare eligible retirees cannot enroll in a High Deductible Health Plan.*

PURCHASING PRESCRIPTION DRUGS AT A PHARMACY

To purchase a prescription drug at a retail pharmacy, present your identification card and prescription to the pharmacist. Prescription drug refills are also covered as long as the prescription is used within one year of the original prescription date, authorized by your physician, and permitted by law.

PARTICIPATING PHARMACIES

Almost all New Jersey pharmacies have elected to participate with the Prescription Drug Plans offered through Express Scripts. To identify a participating pharmacy in your area you may contact Express Scripts, toll free, at 1-866-220-6512 (TTY/TDD 1-800-759-1089) or check on the Internet at: www.medco.com/statenj Once at the home page, click on "Find a Local Pharmacy."

When using a participating pharmacy, present your identification card and prescription. The pharmacist will complete the transaction and process your prescription. The submission of a claim form is not required. You will be asked only to pay the appropriate copayment/coinsurance for any covered medication.

If you have forgotten your identification card, or are waiting for a new one, request your pharmacist to confirm coverage by entering “STATENJ” as your group number and contacting Express Scripts Pharmacy Services Help Desk to obtain your Express Scripts ID number. Otherwise, you may have to pay the full cost of the prescription drug to the pharmacist. However, you will still be entitled to the benefits of this plan. Simply obtain a detailed pharmacy receipt for each prescription and forward it along with a claim form to Express Scripts for reimbursement. Your reimbursement will be based on the participating pharmacy allowance less your copayment (see below, “How to File a Claim for Reimbursement”).

NON-PARTICIPATING PHARMACIES

Over 60,000 pharmacies participate with Express Scripts. However, some pharmacies in New Jersey and in other states do not have agreements with Express Scripts and are not part of the Employee Prescription Drug Plans. When using a non-participating pharmacy, you will be asked to pay the full cost of the prescription drug to the pharmacist. You then must file a claim for reimbursement with Express Scripts.

Your reimbursement will be based on the participating pharmacy allowance for the cost of the medication less your copayment. **If the non-participating pharmacy charges more than the allowance for a participating pharmacy, you will not be reimbursed for the difference.**

How to File a Claim for Reimbursement

1. If you have to file a claim for reimbursement, obtain a detailed pharmacy receipt for each prescription which includes the:
 - Patient’s first and last name;
 - Prescription number;
 - Date the prescription was filled;
 - Name, address, and NABP number of the pharmacy;
 - National Drug Code number;
 - Name and strength of the drug or NDC number;
 - Quantity and form;
 - Days of supply;
 - “Dispense as written” or “Substituted for”;
 - Doctor’s name and DEA number; and
 - Cost of the prescription drug.
2. Obtain a *Prescription Drug Reimbursement Form* from the Division of Pensions and Benefits Web site (see page 40), by calling Express Scripts Member Services at: 1-866-220-6512 (TTY/TDD 1-800-759-1089) or at: www.medco.com/statenj
3. Send the completed *Prescription Drug Reimbursement Form*, along with your pharmacy receipt(s), to the address on the claim form.

Claims should be filed as soon as possible. The filing deadline is one year following the end of the calendar year of the dispensing date. Information about claims or coverage can be obtained by calling Express Scripts Member Services at 1-866-220-6512 (TTY/TDD 1-800-759-1089).

Compound Claim Processing

Effective January 1, 2012, pharmacists nationwide began following a new industry standard. Part of that new standard requires that all ingredients in a compound be identified. To ensure more accurate service, Express Scripts requires the same of member-submitted claims. The following information is needed to process a compound claim.

- List the **valid** 11-digit NDC number for **each** ingredient used for the compound prescription.
- For each NDC number, indicate the “metric quantity” expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- For each NDC number, indicate cost per ingredient.
- Indicate the **total** charge (dollar amount) paid by the patient.
- Receipt(s) must be attached to claim form.

Each ingredient is used in the calculation of the total reimbursement for the compound claim. It is important to provide all items contained in the compound listed above in order to ensure your claim is processed correctly.

MAIL ORDER SERVICES

Express Scripts Mail Order is designed for participants taking medication on an ongoing basis, such as medication to reduce blood pressure, treat asthma, diabetes, or for any chronic health condition. All mail order service prescriptions are filled by registered pharmacists who are available for emergency consultations 24 hours a day, seven days a week by contacting Express Scripts Member Services at 1-866-220-6512 (TTY/TDD 1-800-759-1089).

How the Mail Order Service Works

When you order maintenance drugs that you take on a regular basis through Express Scripts Mail Order, you get larger quantities of medication at one time – up to a 90-day supply for only one copayment per prescription.

If you have an immediate need for your initial prescription, it is suggested that you ask your physician to provide you with two prescriptions, one for a 90-day supply of needed medications plus refills, the second for a 30-day supply of medication. The 30-day prescription should be filled at your local pharmacy for your use while your mail order prescription is being processed.

The first time you use Express Scripts Mail Order, you will need to complete a *Mail-Order Form* and a *Health, Allergy & Medication Questionnaire* (required with each family member’s first order).

Questionnaire data is stored and referenced each time a new prescription is processed to ensure against drug reactions. Be sure to provide answers to all of the information requested.

An Express Scripts *Mail-Order Form* is required with your prescription. Obtain a *Mail-Order Form* from the Division of Pensions and Benefits Web site (see page 40), by calling Express Scripts Member Services at 1-866-220-6512, or at: www.medco.com/statenj

Mail your prescription along with your completed *Mail-Order Form* and the appropriate copayment, to the address on the order form. You may pay by Visa®, MasterCard®, Discover®, American Express®, Diners Club® or by check or money order. Please do not send cash.

Your mail order prescription is reviewed by a pharmacist, dispensed by the pharmacist, and verified through quality control prior to mailing. Your order will be processed and your medications will be sent to you along with reorder instructions and a postage paid envelope for future prescription drugs and/or refills. Express shipping is available for an additional charge.

Transfer an Existing Prescription

For a fast and easy way to use mail order, call Express Scripts Member Services at 1-866-220-6512 (TTY/TDD 1-800-759-1089). Tell the representative that you would like to transfer your prescription from your retail pharmacy to Express Scripts Mail Order. Have your prescription drug container handy. You will need information off the label along with your medical history and the prescribing physician's name and telephone number. The Express Scripts pharmacist will contact your doctor to authorize a new prescription on your behalf. Your prescription will then be promptly filled, and your medication will arrive at your home within 14 days.

New Prescriptions Submitted by Phone from Your Doctor

You can ask your doctor to call Express Scripts Easy Rx Line at 1-888-327-9791 to order a new prescription through Express Scripts Mail Order. You may also ask your doctor to fax your new prescription directly to Express Scripts. Have your doctor fax the request to Express Scripts Member Services at 1-800-837-0959 for additional instructions. **Express Scripts cannot accept faxes from members.**

Online Access

Many of Express Scripts Mail Order's services are available over the Internet at: www.medco.com/statenj where you can:

- Refill your Mail Order Service prescriptions.
- Check the status of a refill order.
- Obtain Mail Order Service forms.

Obtaining Refills Through the Mail Order Service

To help ensure you never run short of your prescription medication, you should reorder when you have 14 days of medication left. The proper copayment amount will be billed to the credit card on file with Express Scripts provided you designated the card to be billed on your prior order.

There are three ways to order refills:

By Telephone: Simply call Express Scripts Member Services at 1-866-220-6512, 24 hours a day, 7 days a week (TTY/TDD 1-800-759-1089). Have your refill slip with your prescription information ready. Use the simple voice instructions to enter your member ID number and the prescription number of the medication that you are requesting. Your prescription medication will be sent to your home.

Over the Internet: If you have Internet access, you may refill your prescription online. Log on to the Express Scripts Web site at: www.medco.com/statenj (pre-registration is required). Then click the link to refill a prescription, check the box next to the prescription you want to order, and click “add to shopping cart.” After you have selected all the prescriptions for your refill order, go to the shopping cart and you will see a detailed summary of your order, including costs. Complete your order by providing payment information and indicating your shipping preference.

By Mail: With your original prescription medication, you will receive a pre-addressed envelope and a notice showing the number of times it may be refilled. Mail this refill notice with your copayment to Express Scripts in the envelope provided.

Note: Prescriptions for certain perishable drugs and those sensitive to heat and cold should be processed at a participating pharmacy nearest your home. If processed through Express Scripts Mail Order or Accredo, Express Scripts’ specialty pharmacy, you will be advised prior to shipment of the mailing date to ensure someone is home to receive the delivery.

COVERAGE AND SERVICES PROVIDED BY THE PRESCRIPTION DRUG PLANS

Your Prescription Drug Plan helps meet the cost of drugs prescribed for you and your covered dependents for use outside of hospitals, skilled nursing facilities, or other institutions. As required by Federal Law, covered drugs can be dispensed only upon a written prescription ordered by a physician.

The following are covered benefits unless listed as an exclusion:

- Federal legend drugs.
- Compounded medications (all ingredients must be covered federal legend drugs).
- Insulin.
- Oral and injectable contraceptives and contraceptive patches. The Patient Protection and Affordable Care Act (PPACA) requires certain women’s preventive services to be covered with no cost sharing. Effective January 1, 2013, all FDA-approved generic prescription contraceptives and brand name prescription contraceptives without generic equivalents will have no copayment. Brand name prescription contraceptives with generic equivalents will continue to be charged the applicable brand name copayment.
- Infertility drugs.
- Over-the-counter diabetic supplies, including test kits and test strips.
- Disposable needles and syringes for diabetic use only.
- Preventive Medications — see chart on page 14.

Dispensing Limits

The maximum amount of a drug which is allowed to be dispensed per prescription or refill:

- **Retail Pharmacy** — up to a 90-day supply (copayment required for each 30-day increment).
- **Mail Order Service** — up to a 90-day supply.

PREVENTIVE MEDICATIONS			
Drug	Preventive Service Guidelines	Coverage Details	Example Covered Drugs
Aspirin	Men – Age 45-79 or Women – Age 55-79 75 and 100mg per day 100 and 325mg every other day	Covered for males, age 45 years through 79 years Covered for females, age 55 years through 79 years	Halfprin Ecotrin Genacote Empirin Enteric Coated Aspirin Bayer Aspirin Children's Aspirin Low Dose Aspirin St. Joseph Aspirin Bayer Children's Aspirin Adult Low Dose Aspirin Baby Aspirin
Fluoride	For preschool children (age greater than 6 months) with low fluoride exposure (water source deficient of fluoride), primary care physicians should prescribe oral fluoride supplements	Covered through age 5. Not covered for those age 6 and older.	Luride Fluoritab Sodium Fluoride Epiflur Ethedent
Folic Acid	Applies to women who are planning and capable of pregnancy. 0.4 to 0.8mg per day	Covered for females through the age of 50 years only	Folic Acid (generic)
Iron	Routine iron supplementation for asymptomatic children age 6-12 months who are at increased risk of iron deficiency anemia.	Covered for those under the age of 1 year; Not Covered for those age 1 year and older	Fer-in-sol Fer-gen-sol Ed-in-sol Fer-iron Ferrous Sulfate Siderol
Smoking Cessation	Combination therapy with counseling and medications is more effective at increasing cessation rates. For non-pregnant adults (greater than 18 years) therapy includes nicotine replacement therapy (gum, lozenge, patch, inhaler, and nasal spray) and sustained release bupropion and varenicline.	Covered for those age 18 and older Note: clinical edits limiting quantities to 180 days supply in any 365 day period apply for ALL smoking cessation drugs.	Nicotrol Nicotrol NS Nicotine Thrive Nicotine Chantix Buproban Nicotine Gum Nicoderm CQ Nicorette Commit Zyban Bupropion SR Nicorelief Stop Smoking Aid Nicotine Transdermal System Bupropion HCL ER

List is subject to change.

Utilization Management

The Prescription Drug Plans include various procedural and administrative rules and requirements designed to ensure appropriate prescription drug usage and to encourage the use of cost-effective drugs. Through these efforts, plan members benefit by obtaining safe amounts of appropriate prescription drugs in a cost-effective manner. The following utilization management programs are part of the Prescription Drug Plans:

- **Quantity Management** — Limits the maximum amount of one medication you may receive over a period of time. Prescription drugs may have a limit for any of the following reasons:
 - Safety.
 - Clinical guidelines and prescribing patterns.
 - Potential for inappropriate use.
 - FDA-approved dosing regimen(s).

Prescription drugs are not eligible to be refilled until 75 percent of the last ordered and dispensed supply period has passed. (i.e. a refill for a 30-day supply will be honored after 23 days have passed.)

Volume restrictions currently apply to certain drugs such as sexual dysfunction drugs (Viagra, Muse, etc.)

- **Step Therapy** — Requires prior authorization of certain more costly prescription drugs, where such drugs have shown no added benefit regarding efficacy or side effects over lower cost therapeutic alternatives. Step Therapy may require a trial of lower cost prescription drugs before approval of the higher cost prescription drug, where clinically appropriate. Step Therapy programs may be used to monitor the use of new medications that come on the market (second line agents) or select classifications of drugs.
- **Preferred Drug Step Therapy (PDST) *** — Under PDST, a member is required to try and fail a lower cost prescription drug before approval of a high cost prescription drug in the following classes of drugs: Proton Pump Inhibitors (ulcer/reflux drugs), SSRI/SSNRI antidepressants, osteoporosis drugs, nasal steroids, and hypnotics. Standard copayments (see pages 3-7) apply for prescription drugs approved under the PDST including higher cost prescription drugs that are found to be clinically appropriate. The chart on page 16 lists medications that are subject to PDST. If you fill a prescription for one of the medications in the first column without getting prior approval, you'll be responsible for the drug's entire cost. If you have tried a medication in column three and failed, your physician can request a coverage review by calling, toll-free, 1-800-417-1764, 8:00 a.m. to 9:00 p.m., eastern time, Monday through Friday. If coverage is approved, you'll pay the plan's appropriate copayment for the medication, which may be higher than what you would pay for the preferred alternatives. **In the third column of the chart are medications that can treat the same condition as those in the first column and are preferred by your plan.** You can fill prescriptions for these medications without a coverage review, and you'll pay the appropriate copayment. Ask your doctor whether one of the preferred alternatives would be right for you.

**PDST does not apply to certain State employees and their dependents or to Medicare eligible retirees.*

MEDICATIONS UNDER PREFERRED DRUG STEP THERAPY (PDST)		
Medications Requiring a Coverage Review	Category	Preferred Medications Available Without a Coverage Review
Aciphex	Gastrointestinal (proton pump inhibitors)	Omeprazole, Pantoprazole, Nexium
Actonel, Actonel with alcium, Atelvia	Osteoporosis (bisphosphonates)	Alendronate, Boniva
Atacand, Atacand HCT	High blood pressure/hypertension (ARBs)	Losartan, Losartan HCTZ , Diovan, Diovan HCT, Micardis, Micardis HCT
Axert	Migraines (triptans)	Sumatriptan, Naratriptan, Maxalt, Maxalt MLT, Relpax
Beconase AQ	Allergy (intranasal steroids)	Flunisolide, Fluticasone, Triamcinolone Acetonide NS, Nasone
Benicar, Benicar HCT, Edarbi	High blood pressure/hypertension (ARBs)	Losartan, Losartan HCTZ , Diovan, Diovan HCT, , Micardis, Micardis HCT
Edluar	Sleep medications (hypnotics)	Generic drugs, including Zolpidem & Zolpidem extended release
Fosamax D	Osteoporosis (biphosphonates)	Alendronate, Boniva
Frova	Migraines (triptans)	Sumatriptan, Naratriptan, Maxalt, Maxalt MLT, Relpax
Dexilant	Gastrointestinal (proton pump inhibitors)	Omeprazole, Pantoprazole, Nexium
Lansoprazole, Lansoprazole rapid dissolve tablets	Gastrointestinal (proton pump inhibitors)	Omeprazole, Pantoprazole, Nexium
Luvox CR, Pexeva	Depression (SSRIs)	Escitalopram, Citalopram, Fluoxetine, Fluvoxamine, Paroxetine, Sertraline
Lunesta	Sleep medications (hypnotics)	Generic drugs, including Zolpidem & Zolpidem extended release
Omnaris	Allergy (intranasal steroids)	Flunisolide, Fluticasone, Triamcinolone Acetonide NS, Nasonex
Prevacid, Prilosec Oral Suspension Protonix (tablets & packets)	Gastrointestinal (proton pump inhibitors)	Omeprazole, Pantoprazole, Nexium
Rhinocort Aqua	Allergy (intranasal steroids)	Flunisolide, Fluticasone, Triamcinolone Acetonide NS, Nasonex
Rozerem	Sleep medications (hypnotics)	Generic drugs, including Zolpidem & Zolpidem extended release
Teveten, Teveten HCT	High blood pressure/hypertension (ARBs)	losartan, losartan HCTZ, , Diovan, Diovan HCT, , Micardis, Micardis HCT
Treximet	Migraines (triptans)	Sumatriptan, Naratriptan, Maxalt, Maxalt MLT, Relpax
Veramyst	Allergy (intranasal steroids)	Flunisolide, Fluticasone, Triamcinolone Acetonide NS, Nasonex
Zegerid omeprazole/sodium bicarbonate	Gastrointestinal (proton pump inhibitors)	Omeprazole, Pantoprazole, Nexium
Zomig, Zomig ZMT	Migraines (triptans)	Sumatriptan, Naratriptan, Maxalt, Maxalt MLT, Relpax

List is subject to change.

- **Dose Optimization Program** — A drug utilization management process encouraging safe and appropriate use of once-per-day medications. Prescriptions are reviewed for multiple daily drug doses of a lower strength medication where a higher strength, once daily dose is equally effective. Dose optimization limits are applied to the number of pills per day for certain medications, where the use of multiple pills to achieve a daily dose is not supported by medical necessity.
- **Prior Authorization** — A mechanism to screen a drug class by specific criteria along with a patient's medical history to determine if the drug is covered under the plan. Prior authorization must be obtained for specific prescription drugs before they are determined to meet the eligibility requirements of the plan.
- **Member High Utilization Management Program** — Pharmacy claims (along with supporting medical data) are evaluated on a periodic basis to identify, document, and correct or deter cases of excessive or abusive utilization.

Under certain circumstances, a pharmacy may not be able to determine at the point of sale, whether a prescription drug is covered. For example, the information on the prescription order may not be sufficient to determine medical necessity and appropriateness. In those circumstances, a member may elect to receive a 96-hour supply of the prescription drug, as a covered benefit, until the determination is made. Alternatively, the member may decide to purchase the prescription drug and submit a claim for benefits. If the claim is denied, no charge in excess of the charge for the 96-hour supply will be covered for that prescription drug or any refill(s) of it.

INFORMATION ABOUT GENERIC DRUGS

What are Generic Drugs?

In many instances, consumers have a choice between brand name drugs and generic drugs. A brand name drug is a medication manufactured by a drug company that has developed and patented the drug. After the drug patent expires, other manufacturers who can meet the FDA production standards may produce and market an equivalent product. These medications, known as generic drugs, are chemically and therapeutically equivalent to their brand name counterparts.

Substitution of drugs in New Jersey is regulated by law. The law stipulates that when a physician indicates "substitution permissible" or gives no indication at all on the prescription, the pharmacist must substitute a generic drug, unless otherwise advised by the patient or prescribing physician that substitution is not permissible.

Who Determines if a Participant can Receive Generic Drugs?

Your physician determines whether a brand name or generic product is dispensed to you. You can take full advantage of the cost savings offered by the Employee Prescription Drug Plan by asking your physician to prescribe a generic drug or write a prescription which allows substitution of a generic drug whenever it is legally permissible.

In general, if your physician writes a prescription that allows only for a brand name drug, the pharmacist will be required to dispense that drug, and you will be required to pay the appropriate higher copayment. If you are interested in taking advantage of the cost savings, be sure to inform your physician of your preference for a generic substitute when he or she is prescribing medications for you and your family. **Note: Certain prescription drugs are subject to step therapy protocols** (see page 16).

WHAT THE PRESCRIPTION DRUG PLANS DO NOT COVER

The following services or supplies are not covered under this plan:

- Non-Federal Legend Drugs.
- State Restricted Drugs.
- Contraceptive jellies, creams, foams, or implants.
- Coinsurance or copayments from another prescription plan.
- Coordination of benefits with prescription and medical plans.
- Needles and syringes (except for diabetic use).
- Oral agents for controlling blood sugar that do not require a prescription.
- Therapeutic devices or appliances including hypodermic needles, syringes, support garments, and other non-medical supplies.
- Immunizing agents, vaccines, and biological sera.
- Blood, blood products, or blood plasma.
- Drugs dispensed or administered in an outpatient setting, including but not limited to, outpatient hospital facilities and physician offices.
- Drugs dispensed by or while confined in a hospital, skilled nursing facility, sanitarium, or similar facility.
- Infusion drugs and drugs that are administered intravenously (IV), except those that are considered specialty and/or are self administered subcutaneously or intramuscularly.
- Drugs for which the cost is recoverable under any Workers' Compensation or occupational Disease Law or any State or Governmental Agency, or medication furnished by another Drug or Medical Service for which no charge is made to the member.
- Drugs prescribed for experimental or investigational indications.
- Drugs dispensed by an unlicensed pharmacy.
- Prescription drugs which lack U.S. Food and Drug Administration (FDA) approval, or which are approved but prescribed for other than a FDA approved use, or in a dosage other than that approved by the FDA.
- Prescription drugs which do not meet medical necessity and appropriateness criteria.
- "Over-the-counter" drugs, or drugs that do not require a prescription written by a licensed practitioner except for preventive medicines as described on page 14.
- Professional charges in connection with administering, injecting, or dispensing of drugs. Specialty drugs may be excluded.
- Durable medical equipment, devices, appliances, and supplies, even if prescribed by a physician.

- Prescription drugs used primarily for cosmetic purposes.
- Prescription drugs for the treatment of erectile dysfunction in excess of the quantity limit of 4 pills in any 30 day period; except for one tablet per day of Cialis 2.5mg or 5mg for treatment of benign prostatic hyperplasia (BPH)
- Prescription drugs to enhance normal functions such as growth hormones for antiaging, steroids to improve athletic performance, or memory enhancing drugs, unless medically necessary.
- Cosmetics and health or beauty aids.
- Special foods, food supplements, liquid diet plans, or any related products.
- Select classes of drugs which have shown no added benefit regarding efficacy or side effects over lower cost therapeutic alternatives.
- Herbal, nutritional, and dietary supplements.
- Prescription drugs with a non-prescription (over-the-counter) chemical and dose equivalent, except insulin.
- Quantities in excess of dispensing limits.
- Early refills, i.e. a refill of a prescription drug before 75 percent of the last ordered and dispensed supply period has passed.

ENROLLING IN THE PRESCRIPTION DRUG PLANS

Levels of Coverage

You may enroll under one of the following levels of prescription drug coverage:

- **Single** — coverage for yourself only.
- **Member/Spouse or Partner*** — coverage for you and your spouse or eligible partner* only.
- **Family** — coverage for you, your spouse or eligible partner*, and eligible children.
- **Parent and Child(ren)** — coverage for you and your eligible children (but not your spouse, if married, or a partner).

When you enroll in a Prescription Drug Plan you will be mailed identification cards indicating your level of coverage.

EMPLOYEE COVERAGE

For all eligible employees, coverage for you and your dependents generally begins on the same date as your health plan coverage. Please refer to the *Summary Program Description* for additional eligibility, enrollment, and coverage information (see page 40 for information on how to obtain this publication).

If you are an employee of a local government or education employer and your employer has resolved to participate in the Employee Prescription Drug Plans at a later date than their initial participation in SHBP or SEHBP coverage, your effective date of prescription drug coverage for you and your dependents will begin as of the date your employer commenced participation in the Employee Prescription Drug Plans.

Transfer of Employment

If you transfer from one SHBP or SEHBP participating employer to another, including transfer within State employment, coverage may be continued without any waiting period provided that:

- You are still enrolled in the SHBP or SEHBP when you begin your new position (COBRA, State part-time, and part-time faculty coverage excluded); **and**

***Spouse** — A member of the opposite sex to whom you are legally married. A photocopy of the *marriage certificate* and additional supporting documentation are required for enrollment.

Civil Union Partner — A person of the same sex with whom you have entered into a civil union. A photocopy of the *New Jersey Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions and additional supporting documentation are required for enrollment. The cost of civil union partner coverage may be subject to federal tax (see your employer or Fact Sheet #75, *Civil Unions*, for details).

Domestic Partner — A person of the same sex with whom you have entered into a domestic partnership as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act. The domestic partner of any State employee, State retiree, or an eligible employee or retiree of a participating local public entity that adopts a resolution to provide Chapter 246 health benefits, is eligible for coverage. A photocopy of the *New Jersey Certificate of Domestic Partnership* dated prior to February 19, 2007 (or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners) and additional supporting documentation are required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer or Fact Sheet #71, *Benefits Under the Domestic Partnership Act*, for details).

- Transfer from one participating employer to another; **and**
- File a *Health Benefits Application* listing the former employer in the appropriate section of the application.

Leave of Absence

Leaves of absence encompass all approved leaves with or without pay. These include:

- Approved leave of absence for illness.
- Approved leave of absence other than illness.
- Family Leave Act (federal and State).
- Furlough.
- Workers' Compensation.
- Suspension (COBRA continuation only — see page 23).

While you are on an approved leave of absence, you may reduce your level of coverage (for financial reasons) for the duration of your leave and increase it again when you return from leave. For example, you can reduce “Family” coverage to either “Parent and Child” or “Single” coverage. Please note that it is necessary to complete a *Health Benefits Application* to decrease your coverage and also to reinstate it once you return to work. Contact your benefits administrator or human resources representative for more information concerning coverage while on leave of absence.

Note: When a leave of absence is due to suspension, you are not eligible for benefits, with the possible exception of enrolling for benefits under the provisions of COBRA (see page 23).

When Coverage Ends

Coverage for you and your dependents will end if:

- You voluntarily terminate coverage;
- Your employment terminates;
- Your hours are reduced so you no longer qualify for coverage;
- You do not make required premium payments;
- You enter the Armed Forces and are eligible for government-sponsored health services;
- Your employer ceases to participate in the SHBP or SEHBP; or
- The SHBP and/or SEHBP are discontinued.

Coverage for your dependents will end if:

- Your coverage ceases for any of the reasons listed above;
- You die (dependent coverage terminates the 1st day of the pay period following the date of death of State employees paid through the State’s Centralized Payroll Unit, or the 1st of the month following the date of death for all other employees);

- Your dependent is no longer eligible for coverage (divorce of a spouse; dissolution of a civil union or domestic partnership; children turn age 26 unless the dependent child qualifies for continuance of coverage due to disability (see the *Summary Program Description* for details); or
- Your enrolled dependent enters the Armed Forces.

If your membership in a Prescription Drug Plan ends, you may be eligible to continue in the Prescription Drug Plan for a limited period of time under the provisions of the federal COBRA law (see page 23).

Certain over age children may be eligible for coverage until age 31 under the provisions of Chapter 375, P.L. 2005 (see the *Summary Program Description* for more information on Chapter 375 coverage.)

You cannot convert a Prescription Drug Plan membership to a private plan.

RETIREE COVERAGE

When you retire, you are not automatically covered as a retiree. You must fill out a *Retired Coverage Enrollment Application* (See Fact Sheet #11, *Enrolling in Health Benefits Coverage When You Retire*, for additional information).

Generally, your employer will continue to cover you in the active employee group for one month beyond your termination of employment. Eligible members whose employer does not participate **in the SHBP or SEHBP will be enrolled as of their retirement date.** (See the *Summary Program Description* for additional information regarding eligibility and enrollment.)

IMPORTANT: In the Retired Group, you and/or your dependent spouse, civil union partner, eligible same-sex domestic partner, or child who is eligible for Medicare coverage by reason of age or disability must be enrolled in both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to enroll or remain in Retired Group coverage. (See the *Summary Program Description* for detailed information).

Medicare Part D

If you are enrolled in the Retired Group of the SHBP/SEHBP and eligible for Medicare, you will be automatically enrolled in the **Express Scripts Medicare™ Prescription Drug Plan (PDP)** a Medicare Part D plan.

Important: If you decide not to be enrolled in Express Scripts Medicare™ (PDP), you will lose your *prescription drug benefits* provided by the SEHBP/SHBP. However, your *medical benefits* will continue. In order to waive the Express Scripts Medicare™ (PDP), you must enroll in another Medicare Part D plan. To request that you not be enrolled, you must submit a *Retired Change of Status Application* waiving your prescription drug coverage.

If you have waived your prescription drug coverage for another Medicare Part D plan, and you wish to re-enroll in the Express Scripts Medicare PDP, you must send proof of your termination from the other Medicare Part D plan. Acceptable proof is a letter confirming the date upon which you are disenrolled from the other Medicare Part D plan. We must receive this proof within 60 days of the termination from the other Medicare part D plan.

COBRA COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federally regulated law that gives employees and their eligible dependents the opportunity to remain in their employer's group coverage when they would otherwise lose coverage because of certain qualifying events. COBRA coverage is available for limited time periods (see "Duration of Coverage" on page 24), and the member must pay the full cost of the coverage plus an administrative fee.

Note: If you are retiring and eligible to enroll in SHBP or SEHBP Retired Group coverage, the Retired Group plan will include a prescription drug benefit and you cannot enroll for coverage under COBRA.

Leave taken under the federal and/or State Family Leave Act is not subtracted from your COBRA eligibility period.

Under COBRA you may elect to enroll in any or all of the coverages that you had as an active employee or dependent (health, prescription drug, dental, and vision), and may change your health or dental plan when enrolling in COBRA. You may also elect to cover the same dependents that were covered while an active employee, or delete dependents from coverage — however, you cannot add dependents who were not covered while an employee except during the annual Open Enrollment period or unless a "qualifying event" (marriage, civil union, birth or adoption of a child, etc.) occurs within 60 days of the COBRA event.

COBRA Events

Continuation of group coverage under COBRA is available if you or any of your covered dependents would otherwise lose coverage as a result of any of the following events:

- Termination of employment (except for gross misconduct).
- Death of the member.
- Reduction in work hours.
- Leave of absence.
- Divorce, legal separation, dissolution of a civil union or same-sex domestic partnership (makes spouse or partner ineligible for further dependent coverage).
- Loss of a dependent child's eligibility through the attainment of age 26.
- The employee elects Medicare as primary coverage. (Federal law requires active employees to terminate their employer's health coverage if they want Medicare as their primary coverage.)

Note: Employees who at retirement are eligible to enroll in SHBP or SEHBP Retired Group coverage cannot enroll for coverage under COBRA.

The occurrence of the COBRA event must be the reason for the loss of coverage for you or your dependent to be able to take advantage of the provisions of the law. If there is no coverage in effect at the time of the event, there can be no continuation of coverage under COBRA.

Continuation of group coverage under COBRA is not permitted for an over age child who loses coverage under Chapter 375 (see the *Summary Program Description* for more information on Chapter 375 coverage).

Cost of COBRA Coverage

If you choose to purchase COBRA benefits, you pay 100 percent of the cost of the coverage plus a two percent charge for administrative costs.

Duration of COBRA Coverage

COBRA coverage may be purchased for up to 18 months if you or your dependents become eligible because of **termination of employment, a reduction in hours, or a leave of absence**.

Coverage may be extended up to 11 additional months, for a total of 29 months, if you have a Social Security Administration approved disability (under Title II or XVI of the Social Security Act) for a condition that existed when you enrolled in COBRA or began within the first 60 days of COBRA coverage. Coverage will cease either at the end of your COBRA eligibility or when you obtain Medicare coverage, whichever comes first.

COBRA coverage may be purchased by a dependent for up to 36 months if he or she becomes eligible because of your **death, divorce, dissolution of a civil union or same-sex domestic partnership**, or he or she becomes ineligible for continued group coverage because of **attaining age 26**.

If a second qualifying event occurs during the 18-month period following the date of any employee's termination or reduction in hours, the beneficiary of that second qualifying event will be entitled to a total of 36 months of continued coverage. The period will be measured from the date of the loss of coverage caused by the first qualifying event.

Employer Responsibilities Under COBRA

The COBRA law requires employers to:

- Notify you and your dependents of the COBRA provisions within 90 days of when you and your dependents are first enrolled;
- Notify you, your spouse/partner, and your children of the right to purchase continued coverage within 14 days of receiving notice that there has been a COBRA qualifying event that causes a loss of coverage;
- Send the *COBRA Notification Letter* and a *COBRA Application* within 14 days of receiving notice that a COBRA qualifying event has occurred;
- Notify the Health Benefits Bureau of the Division of Pensions and Benefits within 30 days of the loss of an employee's coverage; and
- Maintain records documenting their compliance with the COBRA law.

Employee Responsibilities Under COBRA

The law requires that you and/or your dependents:

- Notify your employer (if you are retired, you must notify the Health Benefits Bureau of the Division of Pensions and Benefits) that a divorce, legal separation, dissolution of a civil union or same-sex domestic partnership, or your death has occurred or that your child has reached age 26 — notification must be given within 60 days of the date the event occurred;

- File a *COBRA Application* within 60 days of the loss of coverage or the date of the *COBRA Notice* provided by your employer, whichever is later;
- Pay the required monthly premiums in a timely manner; and
- Pay premiums, when billed, retroactive to the date of group coverage termination.

Failure to Elect COBRA Coverage

In considering whether to elect continuation of coverage under COBRA, an eligible employee, retiree, or dependent (also known as a “qualified beneficiary” under COBRA law) should take into account that a failure to continue group health coverage will affect future rights under federal law.

- First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. The election of continuation of coverage under COBRA may help you to bridge such a gap. (If, after enrolling in COBRA you obtain new coverage which has a pre-existing condition clause, you may continue your COBRA enrollment to cover the condition excluded by the pre-existing condition clause.)
- Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition exclusions if you do not continue coverage under COBRA for the maximum time available to you.
- Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days of the date your group coverage ends. You will also have the same special enrollment right at the end of the COBRA coverage period if you get the continuation of coverage under COBRA for the maximum time available to you.

Termination of COBRA Coverage

Your COBRA coverage will end when any of the following situations occur:

- Your eligibility period expires;
- You fail to pay your premiums in a timely manner;
- After the COBRA event, you become covered under another group insurance program (unless a pre-existing clause applies);
- You voluntarily cancel your coverage;
- Your employer drops out of the SHBP or SEHBP; or
- You become eligible for Medicare after you elect COBRA coverage. (This affects health insurance only, not dental, prescription, or vision coverage.)

APPENDIX I

APPEAL PROCEDURES

Claim Appeal

If you believe an error has been made in processing your prescription drug claim you may call Express Scripts Member Services at 1-866-220-6512, or write to:

**Express Scripts
NJ SHBP/SEHBP Appeals Coordinator
PO Box 14711
Lexington, KY 40512**

Administrative Appeal

An administrative appeal is one for which you believe benefits have been erroneously denied based on the plan's limitations and/or exclusions such as whether a particular drug is covered or a dispensing limit applies for a certain drug. To file an administrative appeal you may call Express Scripts Member Services at 1-866-220-6512, or write to:

**ATTN: Admin Reviews
Express Scripts
8111 Royal Ridge Pkwy
Irving, TX 75063**

Required Information

For either type of appeal, please include the following information in your letter:

- Names and addresses of patient and employee;
- Your prescription drug plan identification number (on your prescription drug ID card);
- Your group number and group name as shown on your prescription drug ID card;
- Employer's name;
- Payment voucher number and date;
- Claim number, if available;
- Date the prescription was filled;
- Pharmacy's name;
- Name of the medication;
- Strength of the medication;
- Quantity prescribed;
- Prescription number;
- Amount billed; and
- Amount you paid.

If your drug claim has been denied and you think the claim should be reconsidered, appeals must be made within 12 months of the date you were first notified of the action being taken to deny your claim. When your appeal is received, the claim will be researched and reviewed. Express Scripts will notify you in writing of the decision on your appeal within 60 days after the appeal is received. Special circumstances, such as delays by you or the provider in submitting necessary information, may require an extension of this 60-day period. The decision on the review will include the specific reason(s) for the decision and refer to specific provisions of the plan on which the decision is based.

Commission Appeal Procedures

For claims incurred prior to January 1, 2012.

After you have exhausted the Express Scripts internal appeal process, if still dissatisfied with the decision, you or your legal representative may appeal, in writing, to the State Health Benefits Commission or School Employees' Health Benefits Commission for claims incurred prior to January 1, 2012 (for claims incurred on or after January 1, 2012, refer to the next section "External Review Procedures"). A request for consideration must include the reason for the disagreement along with copies of all relevant correspondence and should be directed to the following address:

**Appeals Coordinator
Health Benefits Bureau
Division of Pensions and Benefits
PO Box 299
Trenton, NJ 08625-0299**

Notification of all Commission decisions will be made in writing to the member. If the Commission denies the member's appeal, the member will be informed in the denial letter from the Commission of further steps he or she may take.

External Review Procedures

For claims incurred on or after January 1, 2012.

If your claim was incurred on or *after* January 1, 2012, you can request an external review by an Independent Review Organization (IRO) as an additional level of appeal (for claims incurred prior to January 1, 2012 and all Administrative Appeals, please refer to the previous section "Commission Appeal Procedures").

Generally, to be eligible for an independent external review, you must exhaust the two level internal appeal process, unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit claims and appeals or your appeal is urgent. In the case of an urgent appeal, you can submit your appeal in accordance with the identified process in the section "Urgent External Review" on page 28 and also request an external independent review at the same time, or alternatively you can submit your urgent appeal for the independent external review after you have completed the internal appeal process.

To file for an independent external review, your external review request must be received within four (4) months of the date of the adverse benefit determination (if the date that is four months from that date is a Saturday, Sunday, or holiday, the deadline is the next business day). Your request should be mailed or faxed to:

ATTN: External Review Requests
Express Scripts
P.O. Box 631850
Irving, TX 75063-0030
Phone: 1 800-753-2851
Fax: 1-888-235-8551

Non-Urgent External Review

Once you have submitted your external review request, your claim will be reviewed within five (5) business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO) and you will be notified within one (1) business day of the decision.

If your request is eligible to be forwarded to an IRO, your request will be randomly assigned to an IRO and your appeal information will be compiled and sent to the IRO within five (5) business days. The IRO will notify you in writing that it has received the request for an external review and if the IRO has determined your claim is eligible for review, the letter will describe your right to submit additional information within ten (10) business days for consideration to the IRO. Any additional information you submit to the IRO will also be sent to the claims administrator for reconsideration. The IRO will review your claim within 45 calendar days and send you, the plan, and Express Scripts written notice of its decision. If the IRO has determined that your claim does not involve medical judgment or rescission, the IRO will notify you in writing that your claim is ineligible for a full external review.

Urgent External Review

Once you have submitted your urgent external review request, your claim will be immediately reviewed to determine if you are eligible for an urgent external review. An urgent situation is one where in the opinion of your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim.

If you are eligible for urgent processing, your claim will be immediately reviewed to determine if your request is eligible to be forwarded to an IRO, and you will be notified of the decision. If your request is eligible to be forwarded to an IRO, your request will be randomly assigned to an IRO and your appeal information will be compiled and sent to the IRO. The IRO will review your claim within 72 hours and send you, the plan, and Express Scripts written notice of its decision.

HIPAA PRIVACY

The Employee Prescription Drug Plan makes every effort to safeguard the health information of its members and complies with the privacy provisions of the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA requires health plans to maintain the privacy of any personal information relating to its members' physical or mental health. See "Appendix III" (on page 35) for the *Notice of Privacy Practices*.

AUDIT OF DEPENDENT COVERAGE

Periodically, the Division of Pensions and Benefits performs an audit using a random sample of members to determine if enrolled dependents are eligible under plan provisions. Proof of dependency such as marriage, civil union, or birth certificates, or tax returns are required. Coverage for ineligible dependents will be terminated. Failure to respond to the audit will result in termination of ALL coverage and may include financial restitution for claims paid. Members who are found to have intentionally enrolled an ineligible person for coverage will be prosecuted to the fullest extent of the law.

HEALTH CARE FRAUD

Health Care fraud is an intentional deception or misrepresentation that results in an unauthorized benefit to a member or to some other person. Any individual who willfully and knowingly engages in an activity intended to defraud the SHBP or SEHBP will face disciplinary action that could include termination of employment and may result in prosecution. Any member who receives monies fraudulently from a health plan will be required to fully reimburse the plan.

APPENDIX II

GLOSSARY

This section defines certain important terms that relate to the SHBP, SEHBP, and the Employee Prescription Drug Plans.

Civil Union Partner — A person of the same sex with whom you have entered into a civil union. A photocopy of the *New Jersey Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions and additional supporting documentation are required for enrollment. The cost of Civil Union partner coverage may be subject to federal tax (see your employer or Fact Sheet #75, *Civil Unions*, for details).

Copayment/Coinsurance — The amount charged to the eligible member by a retail pharmacy, the Express Scripts mail order pharmacy, or the Express Scripts specialty pharmacy for each prescription drug order or authorized refill.

Drug Enforcement Agency (DEA) Number — A number assigned by the Drug Enforcement Agency to each physician in the United States who prescribes medications.

Dependents — Your eligible dependents are your spouse, civil union partner, or eligible same-sex domestic partner (see page 20) and your children under age 26. Stepchildren, foster children, legally adopted children, and children in a guardian-ward relationship are also eligible. Legal documentation is required with enrollment forms in these cases.

Domestic Partner — A person of the same sex with whom you have entered into a domestic partnership as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act. The domestic partner of any State employee, State retiree, or an eligible employee or retiree of a participating local public entity that adopts a resolution to provide Chapter 246 health benefits, is eligible for coverage. A photocopy of the *New Jersey Certificate of Domestic Partnership* dated prior to February 19, 2007 (or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners) and additional supporting documentation are required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer or Fact Sheet #71, *Benefits Under the Domestic Partnership Act*, for details).

Dose Optimization — A drug utilization management process encouraging safe and appropriate use of once-per-day medications. Prescriptions are reviewed for multiple daily drug doses of a lower strength medication where a higher strength, once daily dose is equally effective. Dose optimization limits are applied to the number of pills per day for certain medications, where the use of multiple pills to achieve a daily dose is not supported by medical necessity.

Drug Utilization Review (DUR) — Drug utilization reviews are performed by Express Scripts to determine a prescription's suitability in light of the patient's health, drug history, drug-to-drug interactions, and drug contraindications

Express Scripts — The pharmaceutical benefits management company that administers the Employee Prescription Drug Plans.

Federal Legend Drug — A drug that, by law, can be obtained only by prescription and bears the label, “Caution: Federal law prohibits dispensing without a prescription.

Local Employee — For purposes of health benefits coverage, a local employee is a full-time employee receiving a salary and working for a Participating Local Employer. Full-time shall mean employment of an eligible employee who appears on a regular payroll and who receives salary or wages for an average number of hours specified by the employer, but not to be less than 25 hours per week, or more if required by contract. It also means employment in all 12 months of the year except in the case of those employees engaged in activities where the normal work schedule is 10 months. In addition, for local coverage, employee shall also mean an appointed or elected officer of the local employer, including an employee who is compensated on a fee basis as a convenient method of payment of wages or salary but who is not a self-employed independent contractor compensated in a like manner. To qualify for coverage as an appointed officer, a person must be appointed to an office specifically established by law, ordinance, resolution, or such other official action required by law for establishment of a public office by an appointing authority. A person appointed under a general authorization, such as to appoint officers or to appoint such other officers or similar language is not eligible to participate in the program as an appointed officer. An officer appointed under a general authorization must qualify for participation as a full-time employee.

Local Employer — Government employers in New Jersey, including counties, municipalities, townships, school districts, community colleges, and various public agencies or organizations.

Mail Order Prescription — A prescription which is dispensed by the designated mail order pharmacy.

Medical Necessity and Appropriateness — Medical necessity and appropriateness criteria and guidelines are established and approved by the Pharmacy and Therapeutics Committee, which consists of practicing physicians and pharmacists. Eligible prescription drugs must meet federal Food and Drug Administration (FDA) approved indications and be safe and effective for their intended use. Drugs administered by a medical professional are not eligible under this plan. A prescription drug is medically necessary and appropriate if, as recommended by the treating practitioner and as determined by Express Scripts medical director or designee(s) it is all of the following:

- A health intervention for the purpose of treating a medical condition;
- The most appropriate intervention, considering potential benefits and harms to the patient;
- Known to be effective in improving health outcomes (For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence; then if necessary, by professional standards; then, if necessary, by expert opinion);
- Cost effective for the applicable condition, compared to alternative interventions, including no intervention. “Cost effective” does not mean lowest price. The fact that an attending practitioner prescribes, orders, recommends, or approves the intervention, or length of treatment time, does not make the intervention “medically necessary and appropriate.”

National Association of Boards of Pharmacy (NABP) Number — Number assigned by the National Association of Boards of Pharmacy to identify the pharmacy. The National Association of Boards of Pharmacy is an independent association that assists its member boards and jurisdictions in developing, implementing, and enforcing uniform standards for the purpose of protecting the public health.

National Drug Code Number (NDC) — A universal drug identification number assigned by the Food and Drug Administration (FDA).

Non-federal Legend Drug — A drug that does not require a prescription and is available “over-the-counter.”

Non-participating Pharmacy — Any pharmacy that does not have an agreement with Express Scripts.

Participating Pharmacy — Any pharmacy which has entered into an agreement with Express Scripts.

Participating Pharmacy Allowance — The maximum amount a retail pharmacy will be reimbursed by Express Scripts for a particular medication. The participating pharmacy allowance is specified in the contract participating pharmacies enter into with Express Scripts.

Pharmacist — A person licensed to practice the profession of pharmacy and who practices in a pharmacy.

Pharmacy — Any place of business which meets these conditions: 1) It is registered as a pharmacy with the appropriate state licensing agency and 2) prescription drugs are compounded and dispensed by a pharmacist. This definition does not include a physician who dispenses drugs, pharmacies or drug centers maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group. It also does not include pharmacies maintained by hospitals, nursing homes, or similar institutions.

Prescription — The request for drugs issued by a physician licensed to make the request in the course of his professional practice.

Prior Authorization — A mechanism to screen a drug/drug class by specific criteria along with a patient’s medical history to determine if the drug is covered under the plan. Prior authorization must be obtained for specific prescription drugs before they are determined to meet the eligibility requirements of the plan.

Public Employer — A federal, state, county, or municipal government, authority, or agency; a local board of education; or a state or county university or college.

Quantity Management — Limits the maximum amount of one medication you may receive over a period of time. Prescription drugs may have a limit for any of the following reasons:

- Safety.
- Clinical guidelines and prescribing patterns.
- Potential for inappropriate use.
- FDA-approved dosing regimen(s).

School Employees' Health Benefits Commission — The entity created by N.J.S.A. 52:14-17.46 and charged with the responsibility of overseeing the School Employees' Health Benefits Program.

School Employees' Health Benefits Program (SEHBP) — The SEHBP was established by Chapter 103, P.L. 2007. It offers medical and prescription drug coverage to qualified school employees and retirees, and their eligible dependents. Local employers must adopt a resolution to participate in the SEHBP. The School Employees' Health Benefits Program Act is found in the N.J.S.A. 52:14-17.46 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

SEHBP Member — An individual who is either a School Employees' Health Benefits Program Active Group, Retired Group, or COBRA participant and their dependents.

SHBP Member — An individual who is either a State Health Benefits Program Active Group, Retired Group, or COBRA participant and their dependents.

Specialty Pharmaceuticals — Oral or injectable drugs that have unique production, administration, or distribution requirements. They require specialized patient education prior to use and ongoing patient assistance while undergoing treatment.

Specialty Pharmaceutical Provider — A provider that dispenses specialty pharmaceuticals.

Spouse — A member of the opposite sex to whom you are legally married. A photocopy of the *marriage certificate* and additional supporting documentation are required for enrollment.

State Biweekly Employee — For health benefits purposes, state biweekly employee means a full-time employee of the State, or an appointed or elected officer, paid by the State's centralized payroll system whose benefits are based on a biweekly cycle. Full-time requires 35 hours per week or more if required by contract.

State Health Benefits Commission — The entity created by N.J.S.A. 52:14-17.27 and charged with the responsibility of overseeing the State Health Benefits Program.

State Health Benefits Program (SHBP) — The SHBP was originally established by statute in 1961. It offers medical, prescription drug, and dental coverage to qualified public employees and retirees, and their eligible dependents. Local employers must adopt a resolution to participate in the SHBP and its plans. The State Health Benefits Program Act is found in the N.J.S.A. 52:14-17.25 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

State Monthly Employee — For health benefit purposes, state monthly employee means a full-time employee of the State, or an appointed or elected officer, whose benefits are based on a monthly cycle and whose payroll system is autonomous (not paid by the State's centralized payroll system). Full-time requires 35 hours per week or more if required by contract.

State Monthly Employer — Employers whose benefits are based on a monthly cycle and whose payroll system is autonomous (not paid by the State's centralized payroll system). This includes state colleges and universities and participating independent state commissions, authorities, and agencies such as:

- Rutgers, the State University of New Jersey
- Palisades Interstate Park Commission
- New Jersey Institute of Technology
- University of Medicine & Dentistry of NJ
- Thomas A. Edison State College
- William Paterson University
- Ramapo State College
- Rowan University
- College of New Jersey
- Montclair State University
- New Jersey City University
- Kean University
- Stockton State College
- New Jersey State Library
- New Jersey State Legislature and Legislative Offices
- New Jersey Building Authority
- New Jersey Commerce and Economic Growth Commission
- Waterfront Commission of New York Harbor
- Agencies or special projects that are supported from, or whose employees are paid from, sources of revenue other than general funds, which other funds shall bear the cost of benefits under this program

Step Therapy — Requires prior authorization of certain more costly prescription drugs, where such drugs have shown no added benefit regarding efficacy or side effects over lower cost therapeutic alternatives. Step Therapy may require a trial of lower cost prescription drugs before approval of the higher cost prescription drug, where clinically appropriate. Step Therapy programs may be used to monitor the use of new medications that come on the market (second line agents) or select classifications of drugs.

APPENDIX III

NOTICE OF PRIVACY PRACTICES TO ENROLLEES

State Health Benefits Program School Employees' Health Benefits Program

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Protected Health Information

The State Health Benefits Program and School Employees' Health Benefits Program (Program) are required by the federal Health Insurance Portability and Accountability Act (HIPAA) and State laws to maintain the privacy of any information that is created or maintained by the programs that relates to your past, present, or future physical or mental health. This Protected Health Information (PHI) includes information communicated or maintained in any form. Examples of PHI are your name, address, Social Security number, birth date, telephone number, fax number, dates of health care service, diagnosis codes, and procedure codes. PHI is collected by the Program through various sources, such as enrollment forms, employers, health care providers, federal and State agencies, or third-party vendors.

The Program is required by law to abide by the terms of this Notice. The programs reserve the right to change the terms of this Notice. If material changes are made to this Notice, a revised Notice will be sent.

Uses and Disclosures of PHI

The Program is permitted to use and to disclose PHI in order for our members to obtain payment for health care services and to conduct the administrative activities needed to run the Program without specific member authorization. Under limited circumstances, we may be able to provide PHI for the health care operations of providers and health plans. Specific examples of the ways in which PHI may be used and disclosed are provided below. This list is illustrative only and not every use and disclosure in a category is listed.

- The Program may disclose PHI to a doctor or a hospital to assist them in providing a member with treatment.
- The Program may use and disclose member PHI so that our Business Associates may pay claims from doctors, hospitals, and other providers.
- The Program receives PHI from employers, including the member's name, address, Social Security number, and birth date. This enrollment information is provided to our Business Associates so that they may provide coverage for health care benefits to eligible members.

- The Program and/or our Business Associates may use and disclose PHI to investigate a complaint or process an appeal by a member.
- The Program may provide PHI to a provider, a health care facility, or a health plan that is not our Business Associate that contacts us with questions regarding the member's health care coverage.
- The Program may use PHI to bill the member for the appropriate premiums and reconcile billings we receive from our Business Associates.
- The Program may use and disclose PHI for fraud and abuse detection.
- The Program may allow use of PHI by our Business Associates to identify and contact our members for activities relating to improving health or reducing health care costs, such as information about disease management programs or about health-related benefits and services or about treatment alternatives that may be of interest to them.
- In the event that a member is involved in a lawsuit or other judicial proceeding, the Program may use and disclose PHI in response to a court or administrative order as provided by law.
- The Program may use or disclose PHI to help evaluate the performance of our health plans. Any such disclosure would include restrictions for any other use of the information other than for the intended purpose.
- The Program may use PHI in order to conduct an analysis of our claims data. This information may be shared with internal departments such as auditing or it may be shared with our Business Associates, such as our actuaries.

Except as described above, unless a member specifically authorizes us to do so, the Program will provide access to PHI only to the member, the member's authorized representative, and those organizations who need the information to aid the Program in the conduct of its business (our "Business Associates"). An authorization form may be obtained over the Internet at: www.state.nj.us/treasury/pensions or by sending an e-mail to: hipaaform@treat.state.nj.us. A member may revoke an authorization at any time.

Restricted Uses

- PHI that contains genetic information is prohibited from use or disclosure by the Programs for underwriting purposes.
- The use or disclosure of PHI that includes psychotherapy notes requires authorization from the member.

When using or disclosing PHI, the Program will make every reasonable effort to limit the use or disclosure of that information to the minimum extent necessary to accomplish the intended purpose. The Program maintains physical, technical and procedural safeguards that comply with federal law regarding PHI. In the event of a breach of unsecured PHI the member will be notified.

Member Rights

Members of the Program have the following rights regarding their PHI.

Right to Inspect and Copy: With limited exceptions, members have the right to inspect and/or obtain a copy of their PHI that the Program maintains in a designated record set which consists of all documentation relating to member enrollment and the Program's use of this PHI for claims resolution. The member must make a request in writing to obtain access to their PHI. The member may use the contact information found at the end of this Notice to obtain a form to request access.

Right to Amend: Members have the right to request that the Program amend the PHI that we have created and that is maintained in our designated record set.

We cannot amend demographic information, treatment records or any other information created by others. If members would like to amend any of their demographic information, please contact your personnel office. To amend treatment records, a member must contact the treating physician, facility, or other provider that created and/or maintains these records.

The Program may deny the member's request if: 1) we did not create the information requested on the amendment; 2) the information is not part of the designated record set maintained by the Program; 3) the member does not have access rights to the information; or 4) we believe the information is accurate and complete. If we deny the member's request, we will provide a written explanation for the denial and the member's rights regarding the denial.

Right to an Accounting of Disclosures: Members have the right to receive an accounting of the instances in which the Program or our Business Associates have disclosed member PHI. The accounting will review disclosures made over the past six years or back to April 14, 2003, whichever period is shorter. We will provide the member with the date on which we made a disclosure, the name of the person or entity to whom we disclosed the PHI, a description of the information we disclosed, the reason for the disclosure, and certain other information. Certain disclosures are exempted from this requirement (e.g., those made for treatment, payment or health benefits operation purposes or made in accordance with an authorization) and will not appear on the accounting.

Right to Request Restrictions: The member has the right to request that the Program place restrictions on the use or disclosure of their PHI for treatment, payment, or health care operations purposes. The Program is not required to agree to any restrictions and in some cases will be prohibited from agreeing to them. However, if we do agree to a restriction, our agreement will always be in writing and signed by the Privacy Officer. The member request for restrictions must be in writing. A form can be obtained by using the contact information found at the end of this Notice.

Right to Restrict Disclosure: The member has the right to request that a provider restrict disclosure of PHI to the Programs or Business Associates if the PHI relates to services or a health care item for which the individual has paid the provider in full. If payment involves a flexible spending account or health savings account, the individual cannot restrict disclosure of information necessary to make the payment but may request that disclosure not be made to another program or health plan.

Right to Receive Notification of a Breach: The member has the right to receive notification in the event that the Programs or a Business Associate discover unauthorized access or release of PHI through a security breach.

Right to Request Confidential Communications: The member has the right to request that the Program communicate with them in confidence about their PHI by using alternative means or an alternative location if the disclosure of all or part of that information to another person could endanger them. We will accommodate such a request if it is reasonable, if the request specifies the alternative means or locations, and if it continues to permit the Program to collect premiums and pay claims under the health plan.

To request changes to confidential communications, the member must make their request in writing, and must clearly state that the information could endanger them if it is not communicated in confidence as they requested.

Right to Receive a Paper Copy of the Notice: Members are entitled to receive a paper copy of this Notice. Please contact us using the information at the end of this Notice.

Questions and Complaints

If you have questions or concerns, please contact the Program using the information listed at the end of this Notice. (Local county, municipal, and Board of Education employees should contact the HIPAA Privacy Officer for their employer.)

If members think the Program may have violated their privacy rights, or they disagree with a decision made about access to their PHI, in response to a request made to amend or restrict the use or disclosure of their information, or to have the Program communicate with them in confidence by alternative means or at an alternative location, they must submit their complaint in writing. To obtain a form for submitting a complaint, use the contact information found at the end of this Notice.

Members also may submit a written complaint to the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201.

The Program supports member rights to protect the privacy of PHI. It is your right to file a complaint with the Program or with the U.S. Department of Health and Human Services.

Contact Office: The Division of Pensions and Benefits
HIPAA Privacy Officer

Address: Division of Pensions and Benefits
Bureau of Policy and Planning
PO Box 295
Trenton, NJ 08625-0295

E-mail: hipaaform@treas.state.nj.us

APPENDIX IV

HEALTH BENEFITS CONTACT INFORMATION

ADDRESSES

Our Mailing Address is Division of Pensions and Benefits
PO Box 299
Trenton, NJ 08625-0299

Our Internet Address is www.state.nj.us/treasury/pensions/health-benefits.shtml

Our E-mail Address is pensions.nj@treas.state.nj.us

TELEPHONE NUMBERS

Division of Pensions and Benefits

Office of Client Services (609) 292-7524
TDD Phone (Hearing Impaired) (609) 292-7718

State Employee Advisory Service (EAS) 24 hours. a day 1-866-EAS-9133
..... 1-866-327-9133

New Jersey State Police

Employee Advisory Program (EAP) 1-800-FOR-NJSP

Rutgers University Personnel Counseling Service

Employee Advisory Program (EAP) (732) 932-7539

University of Medicine and Dentistry of New Jersey

Employee Advisory Program (EAP) (973) 972-5429

New Jersey Department of Banking and Insurance

Individual Health Coverage Program Board 1-800-838-0935
Consumer Assistance for Health Insurance (609) 292-5316
(Press 2)

New Jersey Department of Human Services

Pharmaceutical Assistance to the Aged and Disabled (PAAD) .. 1-800-792-9745

New Jersey Department of Health and Senior Services

Division of Aging and Community Services 1-800-792-8820
Insurance Counseling 1-800-792-8820
Independent Health Care Appeals Program (609) 633-0660

Centers for Medicare and Medicaid Services

Medicare Part A and Part B 1-800-MEDICARE

HEALTH BENEFITS PUBLICATIONS

Publications and fact sheets available from the Division of Pensions and Benefits provide information on a variety of subjects. Fact sheets, handbook, applications, and other publications are available for viewing or printing over the Internet at: www.state.nj.us/treasury/pensions

General Publications

Summary Program Description — an overview of SHBP/SEHBP eligibility and plans

Plan Comparison Summary — out-of-pocket cost comparison charts for State employees, local government employees, local education employees, and all retirees.

Health Benefit Fact Sheets

Fact Sheet #11, *Enrolling in the Health Benefits Coverage When you Retire*

Fact Sheet #23, *Health Benefits and Medicare Parts A & B for Retirees*

Fact Sheet #25, *Employer Responsibilities under COBRA*

Fact Sheet #26, *Health Benefits Options upon Termination of Employment*

Fact Sheet #30, *The Continuation of Health Benefits Coverage under COBRA*

Fact Sheet #37, *Employee Dental Plans*

Fact Sheet #47, *Retired Health Benefits Coverage under Chapter 330 - PFRS & LEO*

Fact Sheet #51, *Continuing Health Benefits Coverage for Over Age Children with Disabilities*

Fact Sheet #60, *Voluntary Furlough Program*

Fact Sheet #66, *Health Benefits Coverage for Part-Time Employees*

Fact Sheet #69, *SHBP Coverage for State Intermittent Employees*

Fact Sheet #71, *Benefits under the Domestic Partnership Act*

Fact Sheet #73, *Retiree Dental Expense Plan*

Fact Sheet #74, *Health Benefits Coverage of Children until Age 31 under Ch. 375, P.L. 2007*

Fact Sheet #75, *Civil Unions*

Health Plan Member Handbooks

Aetna Freedom PPO and Value HD Plans Member Handbook

NJ DIRECT Member Handbook

Aetna HMO Member Handbook

Horizon HMO Member Handbook

Prescription Drug Plans Member Handbook

Employee Dental Plans Member Handbook

Retiree Dental Expense Plan Member Handbook

