

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

EMPLOYEE
PRESCRIPTION DRUG
PLAN
MEMBER HANDBOOK



Department of the Treasury
Division of Pensions and Benefits

Plan Year 2009

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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 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 Employee Prescription Drug Plan is administered for the SHBP and SEHBP by CVS Caremark on behalf of Horizon Blue Cross Blue Shield of New Jersey. CVS Caremark is 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 *Employee Prescription Drug Plan 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 CVS Caremark 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

EMPLOYEE PRESCRIPTION DRUG PLAN

ELIGIBILITY

The **Employee Prescription Drug Plan** is offered to:

- Eligible State of New Jersey employees and their dependents.
- Eligible employees of State colleges and universities and participating independent State commissions, authorities, and agencies and their dependents.
- Eligible employees of Local Government and Local Education employers (and eligible dependents) if the employer has adopted a resolution to participate in the Employee Prescription Drug Plan.

The Employee Prescription Drug Plan 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 31 for information on how to obtain this publication).

PLAN BENEFITS

Plan benefits are available through a participating **retail pharmacy**, the plan's designated **mail order service**, the **CVS Caremark specialty pharmacy**, or from a participating **specialty pharmaceutical provider** for infertility drugs.

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 4.

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 5.

SPECIALTY PHARMACEUTICAL PROVIDER

Specialty pharmaceuticals are a class of medications that are typically produced through biotechnology, administered by injection, and/or require special patient monitoring and handling. Examples of prescription drugs that qualify as specialty pharmaceuticals include, but are not limited to, those used to treat the following conditions: Crohn's Disease; Infertility; Hemophilia; Growth Hormone Deficiency; RSV; Cystic Fibrosis; Multiple Sclerosis; Hepatitis C; Rheumatoid Arthritis; or Gaucher's Disease.

Specialty pharmaceuticals are provided through CVS Caremark Specialty Pharmacy which is the exclusive provider for specialty pharmaceuticals for the Employee Prescription Drug Plan.

If your doctor has prescribed a specialty pharmaceutical, you will not be able to fill the prescription at a retail pharmacy and the pharmacy representative will advise you to contact **CaremarkConnect** at 1-800-237-2767. When calling, identify yourself as a SHBP or SEHBP member. CaremarkConnect will contact your doctor and take care of the appropriate paperwork. Your medication will be shipped directly to your home, office, or doctor's office.

The retail copayment applies for up to a 30-day supply. A mail service copayment applies for a 31- to 90-day supply.

COPAYMENT AMOUNTS

STATE EMPLOYEES

For the 2009 Plan Year, copayments for State employees are as follows:

- **Retail pharmacy or specialty pharmaceutical** provider copayments for up to a 30-day supply are **\$3.00** for generic* drugs; **\$10.00** for brand name prescription drugs *without generic equivalents*; and **\$25.00** for brand name prescription drugs *where a generic equivalent is available*.
- **Mail order** copayments for up to a 90-day supply are **\$5.00** for generic* drugs; **\$15.00** for brand name prescription drugs *without generic equivalents*; or **\$40.00** for brand name prescription drugs *where a generic equivalent is available* (see "Mail Order Services" on page 5 for more information).

LOCAL GOVERNMENT AND LOCAL EDUCATION EMPLOYEES

For the 2009 Plan Year, copayments for employees of a local government or local education employer are as follows:

- **Retail pharmacy or specialty pharmaceutical** provider copayments for up to a 30-day supply are **\$3.00** for generic* drugs; or **\$10.00** for brand name prescription drugs.
- **Mail order** copayments for up to a 90-day supply are **\$5.00** for generic* drugs; or **\$15.00** for brand name prescription drugs (see "Mail Order Services" on page 5 for more information).

*See page 8 for additional information about generic drugs.

PURCHASING YOUR 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

If you use a participating pharmacy, you will pay the appropriate copayment for the purchase of up to a 30, 60, or 90-day maximum supply. Almost all New Jersey pharmacies have elected to participate with the Employee Prescription Drug Plan offered through Horizon Blue Cross Blue Shield of New Jersey and administered by CVS Caremark. To identify a participating pharmacy in your area you may contact CVS Caremark, toll free, at 1-866-881-5605 or check on the Internet at: www.caremark.com. Once at the CVS Caremark home page, click on Pharmacy Locator.

When using a participating pharmacy, present your identification card and prescription(s). The pharmacist will complete all the necessary paperwork and process your prescription as written. The submission of a claim form is not required. You will be asked only to pay the appropriate copayment(s).

If you have forgotten your identification card, or are waiting for a new one, request your pharmacist to enter "StateNJ" as your group number and the employee's Social Security number as the ID number in order to confirm coverage. 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 CVS Caremark for reimbursement. Your reimbursement will be based on the participating pharmacy allowance less your copayment (see "How to File a Claim for Reimbursement" below).

NON-PARTICIPATING PHARMACIES

Over 93 percent of New Jersey pharmacies and 86 percent of the pharmacies nationwide participate with CVS Caremark. However, some pharmacies in New Jersey and in other states do not have agreements with CVS Caremark and are not part of the Employee Prescription Drug Plan. 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 CVS Caremark.

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” of “Substituted for”;
 - Doctor’s name and DEA number; and
 - Cost of the prescription drug.
2. Obtain a *Prescription Reimbursement Claim Form* from the Division of Pensions and Benefits Web site (see page 30), by calling CVS Caremark Customer Care at 1-866-881-5605, or at: www.horizonblue.com/shbp.
 3. Send the completed *Prescription Reimbursement Claim 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 1 year and 90 days following the end of the calendar year of the dispensing date. Information about claims or coverage can be obtained by calling CVS Caremark Customer Care at 1-866-881-5605.

MAIL ORDER SERVICES

The Mail Order Service is designed for participants taking medication on an ongoing basis, such as medication to reduce blood pressure or treat asthma, diabetes, or 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 CVS Caremark Customer Care at 1-866-881-5605.

How the Mail Order Service Works

Mail Order Service is designed for maintenance drugs that you take on a regular basis. When you order by mail, 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.

Note: Certain prescription drugs, including specialty pharmaceuticals, self-administered injectable drugs, and other drugs requiring special handling are not available through the mail order pharmacy and should be obtained from the CVS Caremark Specialty Pharmacy or from

a participating specialty pharmaceutical provider for infertility drugs (see page 3). Drugs obtained from retail or specialty providers are subject to a copayment per 30-day supply of medication.

If this is the first time you are using the mail order service, you will need to complete the patient profile information on the back of the *Mail Service Order Form* with each family member's first order.

Your personal patient profile data will be stored and referenced each time a new prescription is processed to assure against drug reactions. Be sure to provide answers to all of the information requested.

A CVS Caremark *Mail Service Order Form* is required with your prescription. Obtain a *Mail Service Order Form* from the Division of Pensions and Benefits Web site (see page 30), by calling CVS Caremark Customer Care at 1-866-881-5605, or at: www.horizonblue.com/shbp.

Mail your prescription along with your completed *Mail Service Order Form* and the appropriate copayment, to the address on the order form. You may pay by Visa®, MasterCard®, Discover®, American Express®, 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 the Mail Order Service Quality Control Department prior to mailing.

Your order will be processed and your medications will be sent to you in plain, tamper-evident packaging for security and confidentiality via First Class U.S. Mail, UPS®, or Federal Express®, 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 CVS Caremark Customer Care at 1-866-881-5605. Tell the representative that you would like to transfer your prescription from your retail pharmacy to the Mail Order Service. 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. Your Mail Order Service 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 CVS Caremark's Provider Line at 1-877-278-0347 to order a new prescription through the Mail Order Service.

Please note: *This phone number is for physicians only and is not to be used by patients.*

You may also ask your doctor to fax your new prescription directly to CVS Caremark at 1-877-278-0328. To obtain a *Physician's Fax Form* on behalf of your doctor, call CVS Caremark Customer Care at 1-866-881-5605. **CVS Caremark cannot accept faxes from members.**

New Prescriptions Submitted by Phone from the Member

You can request a new prescription — provided that you have obtained the actual prescription from your physician — over the phone, toll-free at 1-800-875-0867. Provide the Customer Care representative with the following information:

- Member ID number (on your prescription benefit card);
- Medication name;
- Prescribing doctor's name and phone number;
- Shipping address; and
- Credit card number and expiration date.

The representative will contact your doctor to complete the order.

Online Access

The Mail Order Service is available over the Internet at: www.caremark.com 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 CVS Caremark provided you designated the card to be billed on your prior order.

There are three ways to order refills:

By Telephone: Simply call CVS Caremark Customer Care at 1-866-881-5605, 24 hours a day, 7 days a week. Have your refill slip with your prescription information ready. Use the simple voice instructions to enter your member ID number and the 7-digit 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. Go to the CVS Caremark Web site at: www.caremark.com Click the link that says "Refill a Prescription." Enter your login information (preregistration is required) and the prescription number of your medication. You will see a detailed summary of your order, including costs. Review the information and then click on the shopping cart next to the medication to refill your prescription.

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 CVS Caremark in the envelope provided.

Note: Prescriptions for perishable drugs and those sensitive to heat and cold should be processed at a participating pharmacy nearest your home. If processed through the Mail Order Service or the CVS Caremark Specialty Pharmacy, you will be advised prior to shipment of the mailing date to ensure someone is home to receive the delivery.

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.

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.

COVERAGE AND SERVICES PROVIDED BY THE EMPLOYEE PRESCRIPTION DRUG PLAN

Your Employee 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.
- Insulin.
- Oral and injectable contraceptives and contraceptive patches.
- Infertility drugs.
- Over-the-counter diabetic supplies, including test kits and test strips.
- Disposable needles and syringes for diabetic use only.

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.

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

The State Health Benefits Commission and School Employees' Health Benefits Commission reserve the right to establish dispensing limits on any medication based on Food and Drug Administration (FDA) recommendations and medical appropriateness. Prior Authorization, Drug Utilization Review, Dose Optimization, Step Therapy, and the Specialty Pharmacy Program may be employed to ensure that the medications that are reimbursed under the plan are the most clinically appropriate and cost effective. Volume restrictions currently apply to certain drugs such as sexual dysfunction drugs (Viagra, Muse, etc.).

Utilization Management

The Employee Prescription Drug Plan includes various utilization management activities designed to ensure appropriate prescription drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, plan members benefit by obtaining appropriate prescription drugs in a cost-effective manner. Among the programs utilized are the following.

- **Dispensing Quantity Limit** — A dispensing or quantity limit is the maximum amount of one medication you may receive at one time. Prescription drugs may have a limit for any of the following reasons:
 - Safety.
 - Clinical guidelines and prescribing patterns.
 - Potential for inappropriate use.
 - Lower-priced clinical alternatives available.
 - FDA-approved dosing regimen(s).
- **Step Therapy** — Step Therapy encourages a trial of less costly first-line prescription drugs before the use of more costly second line agents. Second line agents are new medications that come on the market. The new medications are determined by the Food and Drug Administration (FDA) to be effective, but not more effective than the medications already on the market.
- **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 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. The program may also identify members who are candidates for case management.

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.

WHAT THE EMPLOYEE PRESCRIPTION DRUG PLAN DOES 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 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 supplied in Unit Dose packaging except when that is the only form distributed to pharmacies.
- 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.

- Professional charges in connection with administering, injecting, or dispensing of drugs.
- Durable medical equipment, devices, appliances, and supplies, even if prescribed by a physician, except prescription contraceptive diaphragms.
- Prescription drugs used primarily for cosmetic purposes.
- Prescription drugs for the treatment of erectile dysfunction in excess of the monthly quantity limit.
- Prescription drugs to enhance normal functions such as growth hormones for anti-aging, steroids to improve athletic performance, or memory enhancing drugs, unless medically necessary.
- Cosmetics and health or beauty aids.
- Drugs for weight reduction or control, special foods, food supplements, liquid diet plans, or any related products.
- Select classes of drugs where non-preferred medications that have therapeutic alternatives have shown no added benefit regarding efficacy or side effects over preferred drugs.
- 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 at a retail pharmacy before 75 percent of the last ordered and dispensed supply period has passed (72 percent for mail order).

ENROLLING IN THE EMPLOYEE PRESCRIPTION DRUG PLAN

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 the Employee Prescription Drug Plan you will be mailed identification cards indicating your level of coverage.

When Coverage Begins

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 31 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 Plan 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 Plan.

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:

***Spouse** — A member of the opposite sex to whom you are legally married. A photocopy of the *marriage certificate* is 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 is required for enrollment. The cost of a civil union partner's 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) is 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).

- You are still enrolled by the SHBP or SEHBP when you begin in your new position (COBRA, State part-time, and part-time faculty coverage excluded); **and**
- Transfer from one participating employer to another; **and**
- File a *NJ 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 15).

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 *NJ 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 15).

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 marry, enter into a civil union or domestic partnership, move out of the household, or turn age 23 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 the Employee Prescription Drug Plan ends, you may be eligible to continue in the Employee Prescription Drug Plan for a limited period of time under the provisions of the federal COBRA law (see below).

You cannot convert Employee Prescription Drug Plan membership to a private 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 16), and the member must pay the full cost of the coverage plus an administrative fee.

Note: If you are retiring and enrolling in SHBP or SEHBP Retired Group coverage, the Retired Group plan will include a prescription drug benefit.

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 independence (moving out of household), the attainment of age 23, marriage, civil union, or domestic partnership.
- 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.)

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 **marriage, civil union, domestic partnership, attaining age 23, or moving out of the household**, or because you **elected Medicare as your primary coverage**.

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 married, entered into a civil union or domestic partnership, moved out of your household, or reached age 23 — 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

CLAIM APPEAL PROCEDURES

If you believe an error has been made in processing your prescription drug claim you may call CVS Caremark Customer Care at 1-866-881-5605, or write to:

**CVS Caremark
NJ SHBP/SEHBP Appeals Coordinator
PO Box 52084
Phoenix, AZ 85072-2084**

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. CVS Caremark 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.

After you have exhausted the CVS Caremark 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. 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 (s)he may take.

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 26) for the *Notice of Privacy Practices*.

DEPENDENT ELIGIBILITY VERIFICATION AUDIT

During 2009 and 2010, a Dependent Eligibility Verification Audit of all members will be performed by Aon Consulting on behalf of the Division of Pensions and Benefits to determine if covered dependents are eligible under plan provisions. Proof of dependency such as a marriage, civil union, and/or birth certificates, and tax returns are required. Coverage for ineligible dependents will be terminated. An amnesty period will be permitted during which employees and retirees will have the opportunity to voluntarily identify and remove any ineligible dependents from coverage and therefore avoid any penalties or other legal action. After the close of the amnesty period, members who are found to have intentionally enrolled an ineligible person for coverage will be prosecuted to the fullest extent of the law. Failure to respond to the audit will result in the termination of dependent coverage.

APPENDIX II

GLOSSARY

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

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 is required for enrollment. (see your employer or Fact Sheet #75, *Civil Unions*, for more information).

Copayment — The amount charged to the eligible member by a retail pharmacy, the CVS Caremark mail order pharmacy, or the CVS Caremark Specialty Pharmacy for each prescription drug order or authorized refill.

CVS Caremark — The pharmaceutical benefits management company that administers the Employee Prescription Drug Plan.

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 13) and your unmarried children under age 23 who live with you in a regular parent-child relationship. (This includes children who are away at school.)

If you are a single parent, divorced, or legally separated, your children who do not live with you are eligible if you are legally required to support those children. Stepchildren, foster children, legally adopted children, and children in a guardian-ward relationship are also eligible provided they live with you and are substantially dependent upon you for support and maintenance. *Affidavits of Dependency* and legal documentation are required with enrollment forms for these cases.

Dispensing Quantity Limit — A dispensing or quantity limit is the maximum amount of one medication you may receive at one time. Prescription drugs may have a limit for any of the following reasons:

- Safety.
- Clinical guidelines and prescribing patterns.
- Potential for inappropriate use.
- Lower-priced clinical alternatives available.
- FDA-approved dosing regimen(s).

Domestic Partner — For health benefits eligibility, a domestic partner is defined under Chapter 246, P.L. 2003, the Domestic Partnership Act, as a person of the same sex with whom the employee or retiree has entered into a domestic partnership by register-

ing with the local registrar and receiving a *New Jersey Certificate of Domestic Partnership* dated prior to February 19, 2007 or a valid certification from another jurisdiction that recognizes same-sex domestic partners. Domestic partner coverage is only available to State employees/retirees and to Local Government/Education employees/retirees whose employer has adopted a resolution to participate in health benefits coverage under the Domestic Partnership Act (see your employer or Fact Sheet #71, *Benefits Under the Domestic Partnership Act*, for more information).

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 CVS Caremark to determine a prescription's suitability in light of the patient's health, drug history, drug-to-drug interactions, and drug contraindications.

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 20 hours per week. 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 Horizon BCBSNJ's 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 CVS Caremark or Horizon Blue Cross Blue Shield of New Jersey.

Participating Pharmacy — Any pharmacy which has entered into an agreement with CVS Caremark or Horizon Blue Cross Blue Shield of New Jersey.

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

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.

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.

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 normally requires 35 hours per week.

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. 52:17.25 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 shall mean the usual full-time weekly schedule for the particular title, which normally requires 35 hours per week.

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 — Step therapy encourages a trial of less costly first-line prescription drugs before the use of more costly second line agents. Second line agents are new medications that come on the market. The new medications are determined by the Food and Drug Administration (FDA) to be effective, but not more effective than the medications already on the market.

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: hipaiform@treas.state.nj.us. A member may revoke an authorization at any time.

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.

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 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.

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

Fax: (609) 341-3410

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/shbp.htm

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

Rutgers University Personnel Counseling Service (EAP) (732) 932-7539

New Jersey State Police

Employee Advisory Program (EAP) (856) 234-5652
..... (908) 231-1077
..... (609) 633-3718
..... 1-800-FOR-NJSP

University of Medicine and Dentistry of New Jersey (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 for State Employees

Plan Comparison Summary for Local Government Employees

Plan Comparison Summary for Local Education Employees

Plan Comparison Summary for 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

NJ DIRECT Member Handbook

Aetna HMO Member Handbook

CIGNA HealthCare Member Handbook

Employee Prescription Drug Plan Member Handbook

Employee Dental Plans Member Handbook

Retiree Dental Expense Plan Member Handbook

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