



Prescription Drug Plans

Member Guidebook

For the State Health Benefits Program (SHBP) and
the School Employees' Health Benefits Program (SEHBP)



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INTRODUCTION

The State Health Benefits Program (SHBP) was established in 1961. It offers medical, prescription drug, and dental coverage to qualified State and local government public employees, retirees, and 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, prescription drug, and dental 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 New Jersey Division of Pensions & Benefits (NJDPB), 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 OptumRx, 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 Guidebook*. However, State law and the New Jersey Administrative Code govern the SHBP and SEHBP. If there are discrepancies between the information presented in this guidebook 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 OptumRx before you receive services to avoid any denial of coverage issues that could result.

If, after reading this guidebook, you have any questions, comments, or suggestions regarding the information presented, please write to the New Jersey Division of Pensions & Benefits, P.O. Box 295, Trenton, NJ 08625-0295, call us at (609) 292-7524, or send an email to: pensions.nj@treas.nj.gov

PRESCRIPTION DRUG PLANS

Eligibility

The Prescription Drug Plans' rules of eligibility and information on maintaining coverage are the same as those for the SHBP and SEHBP medical plans. Please refer to the *Summary Program Description* for additional eligibility, enrollment, and coverage information (see the "Health Benefits Publications" section 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 prescrip-

tion 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.

Plan Benefits

The prescription drug plans can be obtained through a participating pharmacy, through the OptumRx Home Delivery Program, or through BriovaRx, OptumRx's specialty pharmacy service.

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. Additional information can be found in the "Purchasing Prescription Drugs at a Pharmacy" section.

Mail Order Service

Mail order benefits are available where participants can receive up to a 90-day supply of prescription drugs for one copayment. Additional information about mail order service can be found in the "Home Delivery Program" section.

Specialty Pharmaceutical Provider

Specialty pharmaceuticals are provided through BriovaRx (OptumRx's specialty pharmacy), which is the exclusive provider for specialty pharmaceuticals for the Employee Prescription Drug Plans.

If your provider has prescribed a specialty pharmaceutical, you will not be able to fill the prescription at a retail pharmacy. Instead, you should contact BriovaRx at 1-855-427-4682. When calling, identify yourself as a SHBP or SEHBP member. BriovaRx will contact your provider 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 provider's office, via United Parcel Service (UPS).

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

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.

The State Health Benefits Plan Design Committee establishes the copayment amounts on an annual basis. In Plan Year 2020, a State employee or dependent will pay the following copayment amounts:

- If enrolled in NJ DIRECT15 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 without generic equivalents. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$0 for generic drugs; and \$15 for brand name drugs without generic equivalents. For retail pharmacy brand name drugs with generic equivalents, the member pays the applicable generic copay plus the cost difference between the brand drug and the generic drug. For mail order brand name drugs with generic equivalents, the member pays the difference between the brand name drug and the generic drug. The annual out-of-pocket maximum is \$1,630 individually/\$3,260 for family.

- If enrolled in CWA Unity DIRECT/CWA Unity DIRECT 2019,* NJ DIRECT/NJ DIRECT 2019,** NJ DIRECT1525, or Horizon OMNIA, the copayment at a retail pharmacy for up to a 30-day supply is \$7 for generic drugs; and \$16 for brand name drugs without generic equivalents. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$0 for generic drugs; and \$40 for brand name drugs without generic equivalents. For retail pharmacy brand name drugs with generic equivalents, the member pays the applicable generic copayment plus the cost difference between the brand name drug and the generic drug. For mail order brand name drugs with generic equivalents, the member pays the difference between the brand name drug and the generic drug. The annual out-of-pocket maximum is \$1,630 individually/\$3,260 for family.
- If enrolled in NJ DIRECT2030, the copayment at a retail pharmacy for up to a 30-day supply is \$3 for generic drugs; and \$18 for brand name drugs without generic equivalents. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$0 for generic drugs; and \$36 for brand name drugs without generic equivalents. For retail pharmacy brand name drugs with generic equivalents, the member pays the applicable generic copay plus the cost difference between the brand drug and the generic drug. For mail order brand name drugs with generic equivalents, the member pays the difference between the brand name drug and the generic drug. The annual out-of-pocket maximum is \$1,630 individually/\$3,260 for family.

- If enrolled in NJ DIRECT2035, the copayment at a retail pharmacy for up to a 30-day supply is \$7 for generic drugs; and \$21 for brand name drugs without generic equivalents. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$0 for generic drugs; and \$52 for brand name drugs without generic equivalents. For retail pharmacy brand name drugs with generic equivalents, the member pays the applicable generic copay plus the cost difference between the brand drug and the generic drug. For mail order brand name drugs with generic equivalents, the member pays the difference between the brand name drug and the generic drug. For maintenance prescription drugs, mail order is mandatory under these plans. The annual out-of-pocket maximum is \$1,630 individually/\$3,260 for family.
- If enrolled in NJ DIRECT HD1500 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 Employees

The amount that local government 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.

* This plan is for members covered by the Communications Workers of America (CWA) only. Members hired before July 1, 2019, will be enrolled in CWA Unity DIRECT. Members hired after July 1, 2019, will be enrolled in CWA Unity DIRECT 2019.

** Members hired before July 1, 2019, will be enrolled in NJ DIRECT. Members hired after July 1, 2019, will be enrolled in NJ DIRECT 2019.

Local government 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 Benefits Plan Design Committee establishes the copayment amounts on an annual basis.

In Plan Year 2020, a local government employee or dependent will pay the following copayment amounts:

- If enrolled in NJ DIRECT/NJ DIRECT 2019,* the copayment at a retail pharmacy for up to a 30-day supply is \$7 for generic; and \$10 for preferred brand name drugs. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$0 for generic drugs; and \$40 for preferred brand name drugs. For retail pharmacy brand name drugs with generic equivalents, the member pays the applicable generic copay plus the cost difference between the brand drug and the generic drug. For mail order brand name drugs with generic equivalents, the member pays the difference between the brand name drug and the generic drug.
- If enrolled in NJ DIRECT10, NJ DIRECT15, or Horizon HMO, the copayment at a retail pharmacy for up to a 30-day supply is \$3 for generic drugs; and \$10 for preferred and non-preferred brand name drugs. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$0 for generic drugs; and \$15 for preferred and non-preferred brand name drugs. For retail pharmacy brand name drugs with generic equivalents, the member pays the applicable generic copay plus the cost difference between the brand drug and the generic drug. For mail order

brand name drugs with generic equivalents, the member pays the difference between the brand name drug and the generic drug. The annual out-of-pocket maximum is \$1,630 individually/\$3,260 for family.

- If enrolled in NJ DIRECT1525 or Horizon OMNIA, 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 \$0 for generic drugs; \$40 for preferred brand name drugs; and \$88 for non-preferred brand name drugs. For retail pharmacy brand name drugs with generic equivalents, the member pays the applicable generic copay plus the cost difference between the brand drug and the generic drug. For mail order brand name drugs with generic equivalents, the member pays the difference between the brand name drug and the generic drug. The annual out-of-pocket maximum is \$1,630 individually/\$3,260 for family.
- If enrolled in NJ DIRECT2030, 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 \$0 for generic drugs; \$36 for preferred brand name drugs; and \$92 for non-preferred brand name drugs. For retail pharmacy brand name drugs with generic equivalents, the member pays the applicable generic copay plus the cost difference between the brand drug and the generic drug. For mail order brand name drugs with generic equivalents, the member pays the differ-

ence between the brand name drug and the generic drug. The annual out-of-pocket maximum is \$1,630 individually/\$3,260 for family.

- If enrolled in NJ DIRECT2035, the copayment at a retail pharmacy for up to a 30-day supply is \$7 for generic drugs; and \$21 for preferred brand name drugs without generic equivalents. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$0 for generic drugs; and \$52 for preferred brand name drugs without generic equivalents. For retail pharmacy brand name drugs with generic equivalents, the member pays the applicable generic copay plus the cost difference between the brand drug and the generic drug. For mail order brand name drugs with generic equivalents, the member pays the difference between the brand name drug and the generic drug. For maintenance prescriptions, mail order is mandatory under these plans. The annual out-of-pocket maximum is \$1,630 individually/\$3,260 for family.
- If enrolled in NJ DIRECT HD1500 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.

2. The NJ DIRECT Prescription Drug Plan and HMO Prescription Drug Plan:

The NJ DIRECT Prescription Drug Plan is available to local government employees enrolled in NJ DIRECT/NJ DIRECT 2019, NJ DIRECT10, NJ DIRECT15, NJ DIRECT1525, NJ DIRECT2030, or NJ DIRECT2035, when the local public employ-

* Members hired before July 1, 2019, will be enrolled in NJ DIRECT. Members hired after July 1, 2019, will be enrolled in NJ DIRECT 2019.

er 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 DIRECT/NJ DIRECT 2019, NJ DIRECT10, or NJ DIRECT15; 15 percent of the eligible pharmacy price when obtained through a participating retail pharmacy if you are enrolled in NJ DIRECT1525 or NJ DIRECT2030; and 20 percent of the eligible pharmacy price when obtained through a participating retail pharmacy if you are enrolled in NJ DIRECT2035.
- 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; or 60 percent if enrolled in NJ DIRECT2035, when obtained through a non-participating retail pharmacy. There is a \$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 OptumRx's Home Delivery Program.
- Specialty pharmacy services also apply and are provided through BriovaRx, OptumRx's specialty pharmacy.
- The annual out-of-pocket maximum is \$400 individually/\$1,000 for family (combined with medical in-network coinsurance maximum) for

NJ DIRECT/NJ DIRECT 2019, NJ DIRECT10, NJ DIRECT15, and NJ DIRECT1525; \$800 individually/\$2,000 for family (combined with medical in-network coinsurance maximum) for NJ DIRECT2030; and \$2,000 individually/\$5,000 for family (combined with in-network medical coinsurance maximum) for NJ DIRECT2035.

- For maintenance prescription drugs, mail order is mandatory under NJ DIRECT2035.

The HMO Prescription Drug Plan is available to local government employees enrolled in Horizon HMO, 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 OptumRx's Home Delivery Program, and from specialty pharmacy services provided through BriovaRx, OptumRx's 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 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 (or specialty pharmaceutical) copayment for up to a 90-day supply, if authorized by your PCP, is \$0 for generic drugs; \$15 for preferred brand name drugs; and \$25 for non-preferred brand name drugs. For retail pharmacy brand name drugs with generic equivalents, the member pays the applicable generic copay plus the cost difference between the brand drug and the generic drug. For mail order

brand name drugs with generic equivalents, the member pays the difference between the brand name drug and the generic drug. Specialty pharmacy services also apply. The annual out-of-pocket maximum is \$1,630 individually/\$3,260 for family.

Tiered Plans: If enrolled in Horizon OMNIA, 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 \$0 for generic drugs; \$40 for preferred brand name drugs; and \$88 for non-preferred brand name drugs. For retail pharmacy brand name drugs with generic equivalents, the member pays the applicable generic copay plus the cost difference between the brand drug and the generic drug. For mail order brand name drugs with generic equivalents, the member pays the difference between the brand name drug and the generic drug. Specialty pharmacy services also apply.

High Deductible Health Plans (HDHP): If enrolled in NJ DIRECT HD1500 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.

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

Local Education Employees

The amount that local 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 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 School Employees' Health Benefits Plan Design Committee establishes the copayment amounts on an annual basis.

In Plan Year 2020, a local education employee or dependent will pay the following copayment amounts:

- If enrolled in NJ DIRECT ZERO, the copayment at a retail pharmacy for up to a 30-day supply is \$3 for generic drugs; and \$10 for preferred brand name drugs. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$5 for generic drugs; and \$15 for preferred brand name drugs. For both retail pharmacy and home delivery non-preferred brand name drugs with generic equivalents, the member pays the applicable generic copay, plus the cost difference between the brand drug and the generic drug. The annual out-of-pocket maximum is \$1,630 individually/\$3,260 for family.
- If enrolled in NJ DIRECT10, NJ DIRECT15, or Horizon HMO, the copayment at a retail pharmacy for up to a 30-day supply is \$3 for generic drugs; and \$10 for preferred and non-preferred brand name drugs. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$5 for generic drugs; and \$15 for pre-

ferred and non-preferred brand name drugs. The annual out-of-pocket maximum is \$1,630 individually/\$3,260 for family.

- If enrolled in NJ DIRECT1525 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 \$18 for generic drugs; \$40 for preferred brand name drugs; and \$88 for non-preferred brand name drugs. The annual out-of-pocket maximum is \$1,630 individually/\$3,260 for family.
- If enrolled in NJ DIRECT2030 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 \$1,630 individually/\$3,260 for family.
- If enrolled in NJ DIRECT2035 or Horizon HMO2035, the copayment at a retail pharmacy for up to a 30-day supply is \$7 for generic drugs; and \$21 for preferred brand name drugs without generic equivalents. The mail order copayment for up to a 90-day supply is \$18 for generic drugs; and \$52 for brand name drugs without generic equivalents. For both retail pharmacy and mail order brand name drugs with generic equivalents, the member pays the applicable generic copay, plus the cost difference between the brand drug and the generic drug. For main-

tenance prescription drugs, mail order is mandatory under these plans. The annual out-of-pocket maximum is \$1,630 individually/\$3,260 for family.

- If enrolled in NJ DIRECT HD1500, 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.

2. The NJ DIRECT Prescription Drug Plan and HMO Prescription Drug Plan:

The NJ DIRECT Prescription Drug Plan is available to local education employees enrolled in NJ DIRECT ZERO, NJ DIRECT10, NJ DIRECT15, NJ DIRECT1525, NJ DIRECT2030, or NJ DIRECT2035, 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; 15 percent of the eligible pharmacy price when obtained through a participating retail pharmacy if you are enrolled in NJ DIRECT1525 or NJ DIRECT2030; and 20 percent of the eligible pharmacy price when obtained through a participating retail pharmacy if you are enrolled in NJ DIRECT2035. The annual out-of-pocket maximum is \$1,580 individually/ \$3,160 for family.

For NJ DIRECT10 and NJ DIRECT15, the out of pocket maximum is \$400 individually/\$1,000 for family.

- 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; or 60 percent if enrolled in NJ DIRECT2035, when obtained through a non-participating retail pharmacy. There is a \$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 OptumRx's Home Delivery Program at <https://informedrx.rxportal.sxc.com/rxclaim/SONJ/StateofNewJersey.html>
- For maintenance prescription drugs, mail order is mandatory under NJ DIRECT2035.
- Specialty pharmacy services also apply and are provided through BriovaRx, OptumRx's specialty pharmacy.

The HMO Prescription Drug Plan is available to local education employees enrolled in Horizon HMO, Horizon HMO1525, Horizon HMO2030, or Horizon HMO2035, 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 OptumRx's Home Delivery Program, and from specialty pharmacy services provided through BriovaRx, OptumRx's 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 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 (or specialty pharmaceutical) 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. The annual out-of-pocket maximum is \$1,630 individually/\$3,260 for family.
- If enrolled in 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, 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. The annual out-of-pocket maximum is \$1,630 individually/\$3,260 for family.
- If enrolled in 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, 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. The annual out-of-pocket maximum is \$1,630 individually/\$3,260 for family.
- If enrolled in Horizon HMO2035, the copayment at a retail pharmacy for up to a 30-day supply

is \$7 for generic drugs; and \$21 for preferred brand name drugs without generic equivalents. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$18 for generic drugs; and \$52 for brand name drugs without generic equivalents. For both retail pharmacy and mail order brand name drugs with generic equivalents, the member pays the applicable generic copay, plus the cost difference between the brand drug and the generic drug. For maintenance prescription drugs, mail order is mandatory under these plans. The annual out-of-pocket maximum is \$1,630 individually/\$3,260 for family.

High Deductible Health Plans (HDHP): If enrolled in NJ DIRECT HD1500, 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.

3. A private (non-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 for members not enrolled in Medicare Part D are provided via mail through BriovaRx, OptumRx's specialty pharmacy. If your provider 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 OptumRx Medicare Prescription Drug Plan (PDP) — a Medicare Part D Plan.

If you enroll in another Medicare Part D plan, you will lose your prescription drug benefits provided by the SHBP/SEHBP. However, your medical benefits will remain in effect.

You may waive the OptumRx Medicare PDP only if you are enrolled in another Medicare Part D plan. To request that your coverage be waived, you must submit proof of enrollment in another Medicare Part D plan.

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

Effective January 1, 2020, copayment amounts for retiree prescription drug coverage are as follows:

State Retirees and Local Government* Retirees

- If enrolled in NJ DIRECT10** or NJ DIRECT15,** the copayment at a retail pharmacy for up to a

30-day supply is \$10 for generic drugs; \$22 for preferred brand name drugs; and \$44 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; \$28 for preferred brand name drugs; and \$55 for non-preferred brand name drugs. For both retail pharmacy and mail order brand name drugs with generic equivalents, the member pays the applicable generic copay, plus the cost difference between the brand drug and the generic drug. The annual out-of-pocket maximum is \$1,351 per person/\$2,702 for family.

- If enrolled in 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 \$24 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. For both retail pharmacy and mail order brand name drugs with generic equivalents, the member pays the applicable generic copay, plus the cost difference between the brand drug and the generic drug. The annual out-of-pocket maximum is \$1,351 per person/\$2,702 for family.
- If enrolled in NJ DIRECT, NJ DIRECT1525, 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. For both retail pharma-

cy and mail order brand name drugs with generic equivalents, the member pays the applicable generic copay, plus the cost difference between the brand drug and the generic drug. The out-of-pocket maximum is \$1,351 per person/\$2,702 for family.

- If enrolled in NJ DIRECT2030 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. For both retail pharmacy and mail order brand name drugs with generic equivalents, the member pays the applicable generic copay, plus the cost difference between the brand drug and the generic drug. The out-of-pocket maximum is \$1,351 per person/\$2,702 for family.
- If enrolled in Horizon OMNIA,** 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 \$18 for generic drugs; \$40 for preferred brand name drugs; and \$88 for non-preferred brand name drugs. For both retail pharmacy and mail order brand name drugs with generic equivalents, the member pays the applicable generic copay, plus the cost difference between the brand drug and the generic drug. The out-of-pocket maximum is \$1,351 per person/\$2,702 for family.
- If enrolled in the High Deductible Health Plan NJ DIRECT HD4000,** the prescription drugs are

* These copays do not apply to retirees of local government employers who have a private prescription plan.

** Medicare-eligible retirees cannot enroll in NJ DIRECT10, NJ DIRECT15, Horizon OMNIA, or the High Deductible Health Plan.

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.

- **For State retirees who were covered by the Communications Workers of America (CWA), the International Federation of Professional and Technical Engineers (IPTE), and the American Federation of State, County, and Municipal Employees (AFSCME)** — If enrolled in CWA Unity DIRECT* or NJ DIRECT,* the copayment at a retail pharmacy for up to a 30-day supply is \$7 for generic drugs and \$16 for 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. For both retail pharmacy and mail order brand name drugs with generic equivalents, the member pays the applicable generic copay, plus the cost difference between the brand drug and the generic drug. The out-of-pocket maximum is \$1,351 per person/\$2,702 for family.

Local Education Retirees

- If enrolled in NJ DIRECT ZERO,* the copayment at a retail pharmacy for up to a 30-day supply is \$10 for generic drugs and \$21 for preferred brand name drugs. The mail order (or specialty pharmaceutical) copayment for up to a 90-day supply is \$5 for generic drugs and \$31 for preferred brand name drugs. For both retail pharmacy and mail order brand name drugs with generic equivalents,

the member pays the applicable generic copay, plus the cost difference between the brand drug and the generic drug. The annual out-of-pocket maximum is \$1,411 per person/\$2,822 for family.

- If enrolled in NJ DIRECT10* or NJ DIRECT15,* the copayment at a retail pharmacy for up to a 30-day supply is \$10 for generic drugs; \$21 for preferred brand name drugs; and \$42 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; \$31 for preferred brand name drugs; and \$52 for non-preferred brand name drugs. The annual out-of-pocket maximum is \$1,411 per person/\$2,822 for family.
- If enrolled in 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 \$26 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; \$19 for preferred brand name drugs; and \$31 for non-preferred brand name drugs. The annual out-of-pocket maximum is \$1,411 per person /\$2,822 for family.
- If enrolled in NJ DIRECT1525 or Horizon HMO1525, the copayment at a retail pharmacy for up to a 30-day supply is \$7 for generic drugs; \$17 for preferred brand name drugs; and \$36 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; \$41 for preferred brand name drugs; and \$91 for non-preferred brand name drugs. The annual out-of-pocket maximum is \$1,411 per person/\$2,822 for family.

- If enrolled in NJ DIRECT2030 or Horizon HMO2030, the copayment at a retail pharmacy for up to a 30-day supply is \$3 for generic drugs; \$19 for preferred brand name drugs; and \$48 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; \$37 for preferred brand name drugs; and \$95 for non-preferred brand name drugs. The annual out-of-pocket maximum is \$1,411 per person/\$2,822 for family.
- If enrolled in the High Deductible Health Plan NJ DIRECT HD4000,* 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.

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 provider, and permitted by law.

Participating Pharmacies

Almost all New Jersey pharmacies have elected to participate with the Prescription Drug Plans offered through OptumRx. To identify a participating pharmacy in your area, active employees and non-Medicare-eligible retirees may call 1-844-368-8740. Medicare-eligible retirees may call 1-844-368-8765 or check online

* Medicare-eligible retirees cannot enroll in CWA Unity DIRECT, NJ DIRECT, NJ DIRECT ZERO, NJ DIRECT10, NJ DIRECT15, Horizon OMNIA, or the High Deductible Health Plan.

at: <http://optumrx.com/stateofnewjersey>

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 OptumRx Pharmacy Services Help Desk to obtain your OptumRx 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 OptumRx for reimbursement. Your reimbursement will be based on the participating pharmacy allowance less your copayment (see the "How to File a Claim for Reimbursement" section).

Non-Participating Pharmacies

Over 60,000 pharmacies participate with OptumRx; however, some pharmacies in New Jersey and in other states do not have agreements with OptumRx 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 OptumRx.

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 following:
 - Patient's first and last name;
 - Prescription number;
 - Date the prescription was filled;
 - Name, address, and NABP number of the pharmacy;
 - National Drug Code (NDC) number;
 - Name and strength of the drug or NDC number;
 - Quantity and form;
 - Days of supply;
 - "Dispense as written" or "Substituted for";
 - Provider's name and Drug Enforcement Administration (DEA) number; and
 - Cost of the prescription drug.
2. Obtain a *Prescription Drug Reimbursement Form* by calling OptumRx Member Services at: 1-844-368-8740 (for active employees and non-Medicare-eligible retirees) or 1-844-368-8765 (for Medicare-eligible retirees).
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 OptumRx.

Compound Claim Processing

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.

HOME DELIVERY PROGRAM

OptumRx's Home Delivery Program is designed for participants who require medication on an ongoing basis to treat chronic health conditions such as high blood pressure, asthma, or diabetes, for example. These types of prescriptions are often referred to as maintenance drugs. All home delivery prescriptions are filled by registered pharmacists who are available for emergency consultations 24 hours a day, seven days a week by contacting OptumRx Member Services at 1-844-368-8740 (for active employees and non-Medicare-eligible retirees) or 1-844-368-8765 (for Medicare-eligible retirees).

How the Home Delivery Program Works

When you order maintenance drugs that you take on a regular basis through OptumRx's Home Delivery Program, 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 provider to issue you 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 home delivery prescription is being processed.

Contact OptumRx Member Services at 1-844-368-8740 (for active employees and non-Medicare-eligible retirees) or 1-844-368-8765 (for Medicare-eligible retirees) or on their website: <https://informedrx.rxportal.sxc.com/rxclaim/SONJ/StateofNewJersey.html> for more information on their Home Delivery Program.

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 OptumRx's Home Delivery Program or BrivoRx, OptumRx's 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 provider.

The following are covered benefits unless listed as an exclusion:

- 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. All Food and Drug Administration (FDA)-approved generic prescription contraceptives and brand name prescription contraceptives without generic equivalents have no copayment. Brand name prescription contraceptives with generic equivalents are charged the applicable brand name copayment;
- Note:** If your prescriber believes that the generic equivalent is not appropriate, please contact OptumRx for an exception at 1-844-368-8740 (for active employees and non-Medicare-eligible retirees) or 1-844-368-8765 (for Medicare-eligible retirees).
- Infertility drugs;
- Over-the-counter diabetic supplies, including test kits and test strips;
- Disposable needles and syringes for diabetic use only; and
- Preventive medications — see the "Preventive Medications" chart.

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).

- **Home Delivery Program** — up to a 90-day supply.

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; and/or
 - 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, 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

* PDST does not apply to Medicare-eligible retirees.

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 higher-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 apply for prescription drugs approved under the PDST including higher-cost prescription drugs that are found to be clinically appropriate. The “Medications under Preferred Drug Step Therapy (PDST)” chart 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 will be responsible for the entire cost of the drug. If you have tried a medication in the third column and failed, your provider can request a coverage review. If coverage is approved, you will pay the plan’s appropriate copayment for the medication, which may be higher than what you would pay for the preferred alternatives. The third column of the chart lists 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 will pay the appropriate copayment. Ask your provider whether one of the preferred alternatives may be right for you.
- **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 dispensed to determine if they 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.

Preventive Medications			
Drug	Preventive Service Guidelines	Coverage Details	Example Covered Drugs
Aspirin	Men – Age 45-79; or Women – Age 55-79: 75 and 100 mg per day, 100 and 325 mg every other day.	Covered for males age 45-79; Covered for females age 55-79.	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, and 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 for children through age 5.	Luride, Fluoritab, Sodium Fluoride, Epiflur, and Ethedent.
Folic Acid	Applies to women who are planning and capable of pregnancy; 0.4 to .08 mg per day.	Covered for females through age 50.	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 children under the age of 1 year.	Fer-in-sol, Fer-gen-sol, Ed-in-sol, Fer-iron, Ferrous Sulfate, and 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, and bupropion HCL ER.
Vitamin D	Combination products that also contain calcium (combination of two agents only for the combinations).	Covered for those age 65 and older.	Single entity vitamin D2 or D3 containing 1,000 IU or less per dosage form.

List is subject to change.

Medications under Preferred Drug Step Therapy (PDST)		
Category	Medications requiring a Coverage Review	Preferred Medications Available Without a Coverage Review
Allergy (Intranasal Steroids)	Beconase AQ; Dymista; Flonase; Nasacort AQ; Rhinocort Aqua; Veramyst; Omnaris; and Zetonna.	budesonide; flunisolide (generic Nasarel); fluticasone propionate nasal spray (generic Flonase); Nasonex; triamcinolone acetonide NS (generic Nasacort AQ); and Qnasl.
Depression (Selective Serotonin Reuptake Inhibitors; targets new users only)	Brintellix; Brisdelle; Fluoxetine 60mg (branded product); Pexeva; Celexa; Lexapro; Luvox CR; Paxil/Paxil CR; Prozac/Prozac Weekly; Sarafem; Zoloft; and Viibryd.	escitalopram oxalate (generic Lexapro); citalopram (generic Celexa); fluvoxamine (generic Luvox); fluoxetine (generic Prozac); paroxetine (generic Paxil); and sertraline (generic Zoloft).
Gastrointestinal (Proton Pump Inhibitors)	Aciphex; Dexilant (formerly known as Kapidex); Esomeprazole strontium (branded product); Prevacid (all forms); Prilosec (all forms); Protonix (all forms); Zegerid (all forms); and PrevPac.	omeprazole (generic Prilosec); pantoprazole tablet (generic Protonix); Nexium; lansoprazole; omeprazole/sodium bicarbonate capsules; rabeprazole; and Pylera.
Hypertension (Angiotensin II Receptor Antagonists)	Atacand/Atacand HCT; Avapro/Avalide; Cozaar; Diovan; Diovan HCT; Edarbi; Edarbyclor Hyzaar; Teveten; Teveten HCT; Micardis/HCT; Twynsta; and Exforge.	losartan (generic Cozaar); losartan HCTZ (generic Hyzaar); candesartan/HCTZ; ibresartan/ibresartan HCTZ; valsartan/HCTZ; eprosartan; telmisartan/amlodipine; Azor; Benicar/HCT; Exforge HCT; and Tribenzor.
Migraine Agents (Serotonin 5-HT1 Receptor Agonists)	Axert; Amerge; Frova; Imitrex tablets; Maxalt/MLT; Treximet; Zomig; and Zomig ZMT.	sumatriptan (generic Imitrex); Relpax; rizatriptan; Zolmitriptan; naratriptan and (generic Amerge).
Osteoporosis Therapy (Bisphosphonates)	Actonel; Actonel with calcium; Binosto; Boniva; Fosamax; Fosamax D; and Atelvia.	alendronate (generic Fosamax); ibandronate (generic Boniva); and risedronate.
Sleep Medication	Ambien IR/CR; Edluar; Intermezzo; Lunesta; Rozerem; Silenor; Sonata; and Zolpimist Oral Spray.	generics including zolpidem (generic Ambien); eszopiclone; zolpidem 6.25mg tablet extended release; zolpidem 12.5mg tablet extended release; and zaleplon.

List is subject to change.

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 provider indicates “substitution permissible” or gives no indication at all on the prescription, the pharmacist must substitute a generic drug, unless otherwise advised by the prescribing provider that substitution is not permissible.

Who Determines If a Member Can Receive Generic Drugs?

Your provider 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 provider 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 provider 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 provider 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 the “Medications under Preferred Drug Step Therapy (PDST)” chart).

INFORMATION ABOUT COMPOUND DRUGS

Compound Drugs are defined as medications that mix or alter ingredients to create a medication designed to the needs of an individual patient. Many ingredients used in compound medications have not been evaluated for safety and efficacy by the FDA. These ingredients are excluded from coverage through the SHBP/SEHBP prescription drug plans.

If any of the ingredients in a compound medication are not covered under the plan, the entire claim will reject. If you are prescribed a compounded medication that contains excluded ingredients, please ask your prescriber if there is a commercially available, FDA-approved medication that is appropriate for you. If your prescriber believes that the compound is clinically necessary, then the prescriber may initiate a coverage review by contacting OptumRx.

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;
- 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 provider 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 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 in the “Preventive Medications” chart;

- 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 provider;
- Prescription drugs used primarily for cosmetic purposes;
- Prescription drugs for the treatment of erectile dysfunction in excess of the quantity limit of four pills in any 30-day period; except for one tablet per day of Cialis 2.5 mg or 5 mg for treatment of benign prostatic hyperplasia (BPH);
- 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;
- 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; and
- 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 (see the NJDPB website for definition of partner):

- **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 the “Health Benefits Publications” section 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);
- Transfer from one participating employer to another; and
- File a *Health Benefits Enrollment and/or Change Form* 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. 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. Contact your benefits administrator or human resources representative for more information concerning coverage while on a 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 the “COBRA Coverage” section).

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;
- 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 first day of the pay period following the date of death of State employees paid through the State's Centralized Payroll Unit, or the first of the month following the date of death for all other employees and retirees); or
- Your dependent is no longer eligible for coverage (divorce of a spouse; dissolution of a civil union or domestic partnership; children turning age 26 unless the dependent child qualifies for continuance of coverage due to disability (see the *Summary Program Description* for details).

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 the "COBRA Coverage" section).

Certain over age children may be eligible for coverage until age 31 under the provisions of P.L. 2005, c. 375 (Chapter 375) (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

Upon retirement, some members are not automatically covered as a retiree and must fill out a *Non-Medicare or Medicare-Eligible Retiree Health Benefit Enrollment and/or Change Form* (See the *Health Benefits Coverage — Enrolling as a Retiree* Fact Sheet, 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.)

It is important to note that if you are 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).

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 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. See the *COBRA – The Continuation of Health Benefits* Fact Sheet for more information.

APPEAL PROCEDURES**Claim Appeal**

If you believe an error has been made in processing your prescription drug claim, you may call OptumRx Member Services at 1-844-368-8740 (for active employees and non-Medicare-eligible retirees) or 1-844-368-8765 (for Medicare-eligible retirees).

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 OptumRx Member Services at 1-844-368-8740 (for active employees and non-Medicare-eligible retirees) or 1-844-368-8765 (for Medicare-eligible retirees).

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. OptumRx 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.

External Review Procedures

After you have exhausted the OptumRx internal appeal process, if still dissatisfied, you can request an external review by an Independent Review Organization (IRO) as an additional level of appeal.

Generally, to be eligible for an IRO 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 "Urgent External Review" section and also request an external independent review at the same time, or alternatively you can submit your urgent appeal for the IRO external review after you have completed the internal appeal process.

To file for an IRO external review, your request must be received within four 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:

OptumRx
CA106-0286
P.O. Box 25184
Costa Mesa, CA 92626
Fax: 877-239-4565

Non-Urgent External Review

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

If your request is eligible to be forwarded to an IRO, it will be randomly assigned to an IRO and your appeal information will be compiled and sent to the IRO within five 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 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 OptumRx 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 OptumRx 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 the "Notice of Privacy Practices to Members" section.

AUDIT OF DEPENDENT COVERAGE

Periodically, the NJDPB 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.

GLOSSARY

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

Copayment/Coinsurance — The amount charged to the eligible member by a retail pharmacy, the OptumRx Home Delivery Program, or the OptumRx specialty pharmacy for each prescription drug order or authorized refill.

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

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) — DURs are performed by OptumRx 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."

Mail Order Prescription — A prescription which is dispensed by the designated mail order pharmacy, OptumRx's Home Delivery Program.

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 providers and pharmacists. Eligible prescription drugs must meet 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 OptumRx 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 NABP to identify the pharmacy. The NABP 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 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 OptumRx.

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

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

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

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 provider 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 providers licensed to make the request in the course their professional practices.

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.

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; and/or
- FDA-approved dosing regimen(s).

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.

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.

NOTICE OF PRIVACY PRACTICES TO MEMBERS

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 (PHI)

The State Health Benefits Program and School Employees' Health Benefits Program (Programs) 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 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 Programs through various sources, such as enrollment forms, employers, health care providers, federal and State agencies, or third-party vendors.

The Programs are 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 Programs are 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 Programs 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 Programs may disclose PHI to a provider or a hospital to assist them in providing a member with treatment.
- The Programs may use and disclose member PHI so that our Business Associates may pay claims from doctors, hospitals, and other providers.
- The Programs receive 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 Programs and/or our Business Associates may use and disclose PHI to investigate a complaint or process an appeal by a member.
- The Programs 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 Programs may use PHI to bill the member for the appropriate premiums and reconcile billings we receive from our Business Associates.
- The Programs may use and disclose PHI for fraud and abuse detection.
- The Programs 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 Programs may use and disclose PHI in response to a court or ad-

ministrative order as provided by law.

- The Programs 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 Programs 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 Programs will provide access to PHI only to the member, the member's authorized representative, and those organizations who need the information to aid the Programs in the conduct of their business (our Business Associates). An authorization form may be obtained on our website or by sending an email to: hipaafarm@treas.nj.gov 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 Programs 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 Programs maintain 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 Programs 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 Programs maintain in a designated record set which consists of all documentation relating to member enrollment and the Programs' 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 Programs 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, they should contact their 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 Programs 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 Programs; 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 Programs or our Business Associates have disclosed member PHI. The accounting will review disclosures made over the past six years. 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 Programs place restrictions on the use or disclosure of their PHI for treatment, payment, or health care operations purposes. The Programs are 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 Programs

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 Programs 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 Concerns

If you have questions or concerns, please contact the Programs 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 Programs 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 Programs communicate with them in confidence by alternative means or at an alternative location, they must submit their concerns in writing. To obtain a form for submitting concerns, use the contact information found at the end of this Notice.

Members also may submit a written concern 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:

New Jersey Division of Pensions & Benefits
HIPAA Privacy Officer

Address:

New Jersey Division of Pensions & Benefits
Bureau of Policy and Planning
P.O. Box 295
Trenton, NJ 08625-0295

Email: hipaform@treas.nj.gov

HEALTH BENEFITS CONTACT INFORMATION

Health and Dental plan telephone numbers and mailing addresses are located in the individual plan descriptions located in the "Medical Plan Descriptions" section and the "Dental Plan Descriptions" section, respectively.

Addresses

Our mailing address is:

New Jersey Division of Pensions & Benefits
P.O. Box 299
Trenton, NJ 08625-0299

Our website address is:

www.nj.gov/treasury/pensions

Our email address is:

pensions.nj@treas.nj.gov

Telephone Numbers

NJDPB:

Office of Client Services (609) 292-7524

TDD Phone

(Hearing Impaired). TRS 711 (609) 292-6683

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 Behavioral Health Care Employee Advisory Program (EAP). . 1-800-327-3678

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 Division of Aging and Community Services 1-800-792-8820

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 NJDPB provide information on a variety of subjects. Fact sheets, handbook, applications, and other publications are available for viewing or downloading on our website.

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 Benefits Fact Sheets

- *Health Benefits Coverage – Enrolling as a Retiree*
- *Health Benefit Programs and Medicare Parts A & B for Retirees*
- *COBRA – The Continuation of Health Benefits*
- *Termination of Employment Through Resignation, Dismissal, or Layoff*
- *Dental Plans – Active Employees*
- *Health Benefits Retired Coverage Under Chapter 330*
- *Family Status Changes — Employees*
- *Family Status Changes — Retirees*
- *Health Benefits Coverage Continuation for Over Age Children with Disabilities*
- *Health Benefits Coverage for Part-Time Employees*
- *Health Benefits Coverage for State Intermittent Employees*
- *Dental Plans – Retirees*
- *Health Benefits Coverage of Children Until Age 31 Under Chapter 375*
- *Civil Unions and Domestic Partnerships*

Health Plan Member Guidebooks

- *NJ DIRECT/CWA Unity DIRECT Member Guidebook*
- *Horizon HMO Member Guidebook*
- *Horizon OMNIA Member Guidebook*
- *NJ DIRECT HDHP Member Guidebook*
- *Prescription Drug Plans Member Guidebook*
- *Employee Dental Plans Member Guidebook*
- *Retiree Dental Plans Member Guidebook*