

“Preferred brands” means brand name prescription drug products and insulin determined by the provider, to be more cost effective alternatives for prescription drug products and insulin with comparable therapeutic efficacy within a therapeutic class, as defined or recognized in the United States Pharmacopeia or the American Hospital Formulary Service Drug Information, or by the American Society of Health Systems Pharmacists. A drug product for which there is no other therapeutically equivalent drug product shall be a preferred brand. Determinations of preferred brands by the provider shall be subject to review and modification by the Commission.

“Prescription drug plan” means the plan for providing payment for eligible prescription drug expenses of retired members of the State Health Benefits Program and their eligible dependents who participate in the Traditional Plan or the State managed care plan (NJ PLUS) as prescribed by this section.

“Provider” means an insurance company, hospital, medical, or health service corporation, or health maintenance organization under agreement or contract with the Commission to administer the prescription drug plan.

“Retail pharmacy” means a pharmacy, drug store or other retail establishment in this State at which prescription drugs are dispensed by a registered pharmacist under the laws of this State, or a pharmacy, drug store or other retail establishment in another state at which prescription drug products are dispensed by a registered pharmacist under the laws of that state if expenses for prescription drug products dispensed at the pharmacy, drug store or other retail establishment are eligible for payment under the prescription drug plan.

“Other brands” means prescription drug products which are not preferred brands or generic drug products. A new drug product approved by the U.S. Food and Drug Administration which is not a generic drug product shall be included in this category until the provider makes a determination concerning inclusion of the drug product in the list of preferred brands.

(b) As a pilot program from March 20, 2000 to December 31, 2007, payment for eligible prescription drug expenses of retired members of the State Health Benefits Program and their eligible dependents who participate in the Traditional Plan or NJ PLUS shall be provided under the prescription drug plan. Payment for prescription drug expenses or the co-payments required under the prescription drug plan shall not be made under the major medical portion of the Traditional Plan or NJ PLUS. There shall be no annual deductible amount that retired members or their eligible dependents shall satisfy before eligibility for payment of prescription drug expenses under the prescription drug plan.

(c) Eligibility of prescription drug expenses for coverage under the prescription drug plan shall be determined on the same basis as reasonable and necessary medical expenses under the major medical portion of the Traditional Plan and NJ PLUS.

(d) A co-payment shall be required for each prescription drug expense until a retired member or eligible dependent satisfied the maximum annual out-of-pocket expense for a calendar year prescribed in (g) and (h) below. The initial amounts of the co-payments for calendar years 2000 and 2001 shall be as follows:

Type of Drug Product	Retail Pharmacy	Mail-Order Pharmacy
Generic	\$ 5.00	\$ 5.00
Preferred Brands	\$10.00	\$15.00
Other Brands	\$20.00	\$25.00

(e) The supply of a drug product eligible for coverage under the prescription drug plan for each prescription drug expense shall be limited to 30 days if the prescription is filled at a retail pharmacy, and 90 days if the prescription is filled through the mail-order pharmacy.

(f) The co-payment amounts under (d) above shall be reviewed annually and shall be increased by the rate of increase of the average wholesale price for a one-day supply of prescription drug products covered under the prescription drug plan for the immediately preceding fiscal year over the second preceding fiscal year rounded to the nearest whole dollar. The basis for determining an increase in the amounts of co-payments from year to year from the initial amounts shall be the actual results of the calculations to determine the increased amounts, and not the rounded amounts of co-payments applicable for any year or years. The co-payments shall be reviewed initially for calendar year 2002. Since there will not be a full fiscal year of experience for fiscal year 2000 under the prescription drug plan, the experience for fiscal year 2000 shall be annualized on an actuarial basis. The rate of increase in the co-payment amounts for calendar years 2002 and 2003 shall not exceed seven percent.

(g) The amount of out-of-pocket expense that a retired member or eligible dependent shall pay for a calendar year for eligible prescription drug expenses under the prescription drug plan shall be limited initially for calendar years 2000 and 2001 to \$300.00.

(h) The maximum amount of annual out-of-pocket expense under (g) above shall be reviewed annually and shall be increased by the rate of increase in the amount of prescription drug expenses paid per member under the prescription drug plan for the immediately preceding fiscal year over the second preceding fiscal year rounded to the nearest whole dollar. The maximum amount of annual out-of-pocket expense shall be reviewed initially for calendar year 2002. Since there will not be a full fiscal year of experience for fiscal year 2000 under the prescription drug plan, the experience for fiscal year 2000 shall be annualized on an actuarial basis. The rate of increase in the maximum amount of annual out-of-pocket expense for calendar years 2002 and 2003 shall not exceed 15 percent.

(i) Notice of increases in the amounts of the co-payments and the maximum out-of-pocket expense shall be published in

the New Jersey Register and shall be sent to all retirees affected by the increases.

(j) The provider administering the prescription drug plan shall comply with N.J.A.C. 11:4-37.3(c)1 through 4, 6 and 7 in administration of the prescription drug plan.

(k) The Commission may limit the annual increases in the co-payments and the maximum out-of-pocket expense for the following reasons:

1. To limit excessive annual increases which are significantly higher than the trends for the increases over the preceding five years;

2. To maintain an appropriate spread between the categories of co-payment amounts; or

3. To prevent undue hardship to retirees if general economic circumstances in the State or economic circumstances relative to health care for retirees are such that strict application of the formulas for the annual increases in the co-payments or the maximum out-of-pocket expense would produce such hardship.

(l) For calendar year 2006 (January 1, 2006 through December 31, 2006), the out-of-pocket maximum expense limit shall be equivalent to \$1,000. For each calendar year thereafter the out-of-pocket maximum expense limit shall be recalculated pursuant to the provisions of (h) above.

New Rule R.2000 d.116, effective March 20, 2000.

See: 31 N.J.R. 4235(a), 32 N.J.R. 1048(a).

Notice of increase in co-payments and maximum out-of-pocket expenses, effective January 1, 2002.

See: 33 N.J.R. 3774(a).

Public Notice: Notice of increase in co-payments and out-of-pocket expenses, effective January 1, 2004.

See: 35 N.J.R. 4791(b).

Public Notice: Notice of increase in the amounts of co-payments and the maximum out-of-pocket expenses under the retiree prescription drug card plan.

See: 37 N.J.R. 363(b).

Amended by R.2005 d.62, effective February 22, 2005.

See: 36 N.J.R. 4691(a), 37 N.J.R. 627(a).

In (b), substituted "six" for "five" and "2006" for "2005" and substituted references to prescription drug plan for card plan.

Amended by R.2006 d.39, effective January 17, 2006.

See: 37 N.J.R. 3947(a), 38 N.J.R. 829(b).

In (b), deleted "for six years (" and substituted "December 31, 2007" for "March 20, 2006"; added (l).

17:9-6.11 Aggregation of nonconcurrent pension credit to qualify for employer-paid retired SHBP benefits under P.L. 2001, c.209

(a) To qualify for employer-paid SHBP coverage based on combined service in more than one New Jersey public retirement systems, members must:

1. Retire and collect a benefit from each retirement system;

2. Have 25 or more years of nonconcurrent pension service credit in total;

3. Retire from the last retirement system after the effective date of P.L. 2001, c.209, August 15, 2001;

4. Be eligible for employer-paid SHBP coverage immediately prior to retirement from the last contributing employer in the retirement system for retirees of the State or participating local employers. Retirees of the State or participating local employers, except school boards and county colleges, are not eligible for SHBP coverage if they elect a deferred retirement benefit; or

5. Be eligible for employer-paid coverage immediately prior to retirement or separation from a school board or county college in New Jersey. The school board or county college must have been the retiree's last contributing employer in order to receive State-paid SHBP coverage as a retiree of a school board or county college.

(b) In addition to meeting one of the criteria in (a) above, in order to qualify, a member must also notify the Division of Pensions and Benefits that they have an aggregate of 25 or more years of nonconcurrent service in more than one public retirement system in New Jersey. Employer-paid coverage will be effective on the first of the month following the date the eligible member notifies the Division.

(c) The provisions of P.L. 2001, c.209 do not affect the definition of a qualified retiree under the provisions of P.L. 1997, c.330 (see N.J.A.C. 17:9-6.9).

New Rule, R.2003 d.185, effective May 5, 2003.

See: 35 N.J.R. 87(a), 35 N.J.R. 1925(a).

SUBCHAPTER 7. TERMINATION

17:9-7.1 Termination effective date

(a) Cessation of active SHBP employee coverage shall be deemed to occur on the last day of eligibility for the coverage period for which charges have been paid.

(b) If a SHBP subscriber does not remit payment by the end of the month in which payment is due and owing, the SHBP shall notify the member by regular mail that the right to continue coverage will be suspended if payment in full is not remitted within 30 days of the suspension notice. If no payment is made, the SHBP shall generate a notice of termination to the member indicating the termination date and restating the amounts due to reinstate coverage. Termination shall be effective on the last day of the month for which premiums were paid. The SHBP shall not reinstate the member unless the member remits the entire balance due. Once coverage terminates, reinstatement is not automatic and will only be done after a review of the individual's circumstances by the SHBP.