


SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM (SEHBP)


Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered

Services [Freestanding Rx: Local Education PPO 10/15](#)

Coverage Period: 01/01/2023 – 12/31/2023
Coverage for: All Coverage Types | Plan Type: Rx

 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.state.nj.us/treasury/pensions/health-benefits.shtml. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbcglossary>

| Important Questions | Answers | Why This Matters: |
|---|---|--|
| What is the overall deductible ? | \$0. | See the Common Medical Events chart below for your costs for services this plan covers. |
| Are there services covered before you meet your deductible ? | Yes. Preventive care is covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | \$1,820 individual/ \$3,640 family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit ? | Premiums, balance-billing charges and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| Will you pay less if you use a network provider ? | Yes. See https://Optumrx.com/stateofnewjersey or call 1-844-368-8740 for a list of network pharmacies. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). |
| Do you need a referral to see a specialist ? | See separate Medical Plan SBC. | See separate Medical Plan SBC. |

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|---|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | See separate Medical Plan SBC. | See separate Medical Plan SBC. | See separate Medical Plan SBC. |
| | Specialist visit Preventive care/screening/immunization | | | |
| If you have a test | Diagnostic test (x-ray, blood work) | See separate Medical Plan SBC. | See separate Medical Plan SBC. | See separate Medical Plan SBC. |
| | Imaging (CT/PET scans, MRIs) | | | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://Optumrx.com/stateofnewjersey | Generic drugs | \$3 copay/1-30 day supply \$6 / 31-60 day supply \$9 / 61-90 day supply at a retail pharmacy \$5 copay/90 day supply by mail order | In-network copays apply. You are responsible for any charges above the allowed amount. | Utilization Management programs may apply. |
| | Brand drugs | \$10 copay/1-30 day supply \$20 / 31-60 day supply \$30 / 61-90 day supply at a retail pharmacy \$15 copay/90 day supply by mail order | In-network copays apply. You are responsible for any charges above the allowed amount. | Utilization Management programs may apply. |
| | Non-Preferred Brand drugs | \$10 copay/1-30 day supply \$20 / 31-60 day supply \$30 / 61-90 day supply at a retail pharmacy \$15 copay/90 day supply by mail order | In-network copays apply. You are responsible for any charges above the allowed amount. | Utilization Management programs may apply. |
| | Specialty drugs | Brand or generic copayments apply. | Not Covered | Utilization Management programs may apply. Specialty drugs are only available by mail order. |
| If you have outpatient | Facility fee (e.g., ambulatory) | See separate Medical | See separate Medical Plan | See separate Medical Plan SBC. |

[* For more information about limitations and exceptions, see the plan or policy document at www.state.nj.us/treasury/pensions/health-benefits.shtml.]

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| surgery | surgery center) | Plan SBC. | SBC. | |
| | Physician/surgeon fees | | | |
| If you need immediate medical attention | Emergency room care | See separate Medical Plan SBC. | See separate Medical Plan SBC. | See separate Medical Plan SBC. |
| | Emergency medical transportation | | | |
| | Urgent care | | | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | See separate Medical Plan SBC. | See separate Medical Plan SBC. | See separate Medical Plan SBC. |
| | Physician/surgeon fees | | | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | See separate Medical Plan SBC. | See separate Medical Plan SBC. | See separate Medical Plan SBC. |
| | Inpatient services | | | |
| If you are pregnant | Office visits | See separate Medical Plan SBC. | See separate Medical Plan SBC. | See separate Medical Plan SBC. |
| | Childbirth/delivery professional services | | | |
| | Childbirth/delivery facility services | | | |
| If you need help recovering or have other special health needs | Home health care | See separate Medical Plan SBC. | See separate Medical Plan SBC. | See separate Medical Plan SBC. |
| | Rehabilitation services | | | |
| | Habilitation services | | | |
| | Skilled nursing care | | | |
| | Durable medical equipment | | | |
| Hospice services | | | | |
| If your child needs dental or eye care | Children's eye exam | See separate Medical Plan SBC. | See separate Medical Plan SBC. | See separate Medical Plan SBC. |
| | Children's glasses | | | |
| | Children's dental check-up | | | |

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

See separate Medical Plan SBC.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

See separate Medical Plan SBC.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact Optum at 1-844-368-8740. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebda/healthreform

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-609-292-7524.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [*cost sharing*] n/a
- Hospital (facility) [*cost sharing*] n/a
- Other [*cost sharing*] n/a

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,730 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|-----------------|
| Deductibles | \$0 |
| Copayments | \$10 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$12,700 |
| The total Peg would pay is | \$12,710 |

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [*cost sharing*] n/a
- Hospital (facility) [*cost sharing*] n/a
- Other [*cost sharing*] n/a

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$7,404 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$550 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$1,460 |
| The total Joe would pay is | \$2,010 |

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [*cost sharing*] n/a
- Hospital (facility) [*cost sharing*] n/a
- Other [*cost sharing*] n/a

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$1,925 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$1,925 |
| The total Mia would pay is | \$1,925 |

Please note that some of the Limits or Exclusions listed above may be covered under the Medical Plan.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.