


## STATE HEALTH BENEFITS PROGRAM (SHBP)

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

Freestanding Rx: State/Local Government PPO2030


Coverage Period: 01/01/2024 – 12/31/2024

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](http://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 <a href="#">deductible</a> ?	\$0.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$1,890 individual/ \$3,780 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 <a href="#">out-of-pocket limit</a> ?	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 <a href="#">network provider</a> ?	Yes. See <a href="https://Optumrx.com/stateofnewjersey">https://Optumrx.com/stateofnewjersey</a> 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 <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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 <a href="#">provider's office</a> 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.
	<a href="#">Specialist</a> visit			
	<a href="#">Preventive care/screening/immunization</a>			
If you have a test	<a href="#">Diagnostic test</a> (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 <a href="#">prescription drug coverage</a> is available at <a href="https://Optumrx.com/stateofnewjersey">https://Optumrx.com/stateofnewjersey</a>	Generic drugs	\$3 copay/1-30 day supply \$6/31-60 day supply \$9/61-90 day supply at a retail pharmacy \$0 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.
	Preferred Brand drugs	\$18 copay/1-30 day supply \$36 /31-60 day supply at a retail pharmacy \$36 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	\$46 copay/1-30 day supply \$92 /31-60 day supply at a retail pharmacy \$92 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 with a generic equivalent available	You pay the applicable brand copayment as listed above, plus the cost difference between	In-network copays apply. You are responsible for any charges above the allowed amount.	Utilization Management programs may apply. Cost difference does not count towards the out-of-pocket maximum.

[\* For more information about limitations and exceptions, see the plan or policy document at [www.state.nj.us/treasury/pensions/health-benefits.shtml](http://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)	
		the brand drug and the generic drug.		
	<a href="#">Specialty drugs</a>	Brand or generic copayments apply.	Not Covered	Utilization Management programs may apply. Specialty drugs are only available by mail order.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	See separate Medical Plan SBC.	See separate Medical Plan SBC.	See separate Medical Plan SBC.
	Physician/surgeon fees			
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	See separate Medical Plan SBC.	See separate Medical Plan SBC.	See separate Medical Plan SBC.
	<a href="#">Emergency medical transportation</a>			
	<a href="#">Urgent care</a>			
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	See separate Medical Plan SBC.	See separate Medical Plan SBC.	See separate Medical Plan SBC.
	Physician/surgeon fees			
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	See separate Medical Plan SBC.	See separate Medical Plan SBC.	See separate Medical Plan SBC.
	Inpatient services			
<b>If you are pregnant</b>	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			
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	See separate Medical Plan SBC.	See separate Medical Plan SBC.	See separate Medical Plan SBC.
	<a href="#">Rehabilitation services</a>			
	<a href="#">Habilitation services</a>			
	<a href="#">Skilled nursing care</a>			
	<a href="#">Durable medical equipment</a>			
<a href="#">Hospice services</a>				
<b>If your child needs dental or eye care</b>	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			

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### 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](http://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](http://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](http://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*)

<b>Total Example Cost</b>	<b>\$12,730</b>
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#### In this example, Peg would pay:

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

### 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*)

<b>Total Example Cost</b>	<b>\$7,404</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$920
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$1,460
<b>The total Joe would pay is</b>	<b>\$2,380</b>

### 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*)

<b>Total Example Cost</b>	<b>\$1,925</b>
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#### In this example, Mia would pay:

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

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