**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?** | **$200** individual/**$500** family for in-network services. **$800** individual/**$2,000** family for out-of-network services. Deductibles are combined with medical plans. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **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?** | In Network: **$2,000** individual/ **$5,000** family<br>Out of network: **$6,500** individual/ **$13,000** family.<br>Out-of-pocket limits are combined with medical plans. | 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 | 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 |

| | | |
|---|---|---|
| | network pharmacies. | 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 www.optumrx.com/ stateofnewjersey | Generic drugs | 20% coinsurance after deductible $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. Mail order is mandatory for maintenance drugs intended for long term use. If you choose to fill a prescription for a maintenance drug at a retail pharmacy, you will pay 100% of the cost of the drug. Cost difference does not count towards the out-of-pocket maximum. |
| | Brand drugs | 20% coinsurance after deductible | In-network copays apply. You are responsible for any charges above the allowed amount. | |
| | Brand drugs with a generic equivalent available | You pay the applicable brand copayment as listed above, plus the cost difference between the brand drug and the generic | In-network copays apply. You are responsible for any charges above the allowed amount. | |
| | Specialty drugs | 20% coinsurance after deductible | Not Covered | Utilization Management programs may apply. Specialty drugs are only available by mail order. |
| **If you have outpatient surgery** | 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 | | | |

[* 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) | |
| **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. |

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

**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.*

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

## 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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $30 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $12,700 |
| **The total Peg would pay is** | **$12,730** |

### 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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $200 |
| Copayments | $0 |
| Coinsurance | $1,190 |
| *What isn't covered* | |
| Limits or exclusions | $1,460 |
| **The total Joe would pay is** | **$2,850** |

### 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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| 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.