Health Benefits Programs and Medicare Parts A & B for Retirees

Information for:
State Health Benefits Program (SHBP)
School Employees' Health Benefits Program (SEHBP)

MEDICARE AND YOUR HEALTH PLAN

Enrolling in Medicare Parts A and B when you and/or your dependent are eligible is a requirement that must be met in order to maintain your health benefits coverage under the SHBP/SEHBP. Members who enroll will have the option to choose a Medicare Advantage plan through Aetna or a Medicare Supplemental plan through Horizon. With either plan, it is important to verify that your doctor accepts Medicare; if they do not accept Medicare, all expenses incurred for services rendered by these doctors are not eligible for coverage under your medical plan and will not be paid.

The charts in this fact sheet provide an easy way to compare the benefits of Medicare and the plans offered by the health benefits program by summarizing what each plan provides for a specified service. The benefits listed on the charts are selected as those most likely to be of interest to you. To be eligible for these benefits, both Parts A and B of Medicare must be obtained once you become eligible for Medicare.

No one plan is best suited for everyone, so be sure to review plan information on copayments, deductibles, prescription drug costs, and premiums (for retirees who pay the full cost of coverage or a portion of the premium).

Aetna Medicare Advantage Plans

Aetna administers the SHBP/SEHBP Medicare Advantage Plans. Under Aetna plans, the coverage provided is a Medicare Advantage plan, which means that eligible claims are paid by the medical plan. You do not need to coordinate coverage between Medicare and Aetna.

Aetna plans are combined with Medicare and pay eligible expenses directly, replacing the need for claims to first be paid by Medicare and then by a secondary plan.

Horizon Supplemental Plans

Under the Horizon supplemental plans, claims are coordinated by first submitting them to Medicare. This coordination of benefits with Medicare is handled by Horizon.

Benefits and plan procedures remain the same as they did prior to enrolling in Medicare; simply pay the normal copayments to the provider. The deductibles and coinsurance required by Medicare will be paid in full by your medical plan.

You may still have out-of-pocket expenses such as deductibles, coinsurance, and costs above reasonable and customary allowances. These plans will not pay for benefits which should have been covered by Medicare.

If Horizon does not receive your Medicare claim information automatically, you must submit a *Medicare Summary Notice* directly to your plan (this comes with your Medicare reimbursement). Be sure your physician's or provider's name is clearly indicated on the *Medicare Summary Notice.*

Participating Providers

To find a participating physician, contact the plans directly:

- **Aetna Medicare Advantage plans**:
  (SHBP) 1-866-234-3129
  (SEHBP) 1-866-816-3662 or Aetna's website.
- **Horizon supplemental plans**: 1-800-414-7427 or on Horizon's website.

Note: If a provider is not registered with or opts out of Medicare, no benefits are payable under the SHBP/SEHBP for the provider services. The charges would not be considered under the medical plan, and the member will be responsible for the charges.

MEDICARE COVERAGE IS REQUIRED IF ELIGIBLE

Upon retirement, if you and/or your dependent are age 65 or have been on Social Security Disability for 24 months or more, you are required to enroll in Medicare Parts A and B in order to continue participating in the SHBP/SEHBP. If you and/or your dependent have not enrolled in Parts A and B of Medicare, you should contact Social Security to apply 90 days prior to your retired health benefits eligibility date.

Note: To avoid a gap in coverage, it is recommended to apply for Medicare enrollment as early as possible. The Centers for Medicare and Medicaid Services (CMS) generally accepts applications up to 90 days prior to your Medicare eligibility date, and the approval process can take up to 6-8 weeks.

MEDICARE ENROLLMENT PERIODS

Initial Enrollment Period

Medicare has an Initial Enrollment Period which lasts for 7 months, starting three months before the month you turn 65, including your birth month, and ending three months after your birth month. However, if your birthday falls on the first, the Initial Enrollment Period starts 4 months before the month you turn 65 and ends 2 months after your birth month. For example, if your birthday is in July, the Initial Enrollment Period would run from April through October, unless your birthday is July 1, in which case the Initial Enrollment Period would run from March through September.

If you apply prior to your birth month, the effective date will be the first of your birth month unless your birthday falls on the first, in which case it will be the first of the month prior, if the application was submitted prior to this date. For example, if your birthday is July 1, the effective date of your Medicare would be June 1, if the application was submitted prior to June 1.

If you apply during your birth month or later, the effective date will be the first of the month following the Medicare application. For example, if your birthday is July 1 and you don't apply for Medicare until August, the effective date of your Medicare would be September 1.

General Enrollment Period

Medicare's General Enrollment Period runs January 1 through March 31 each year. Coverage starts the first of the month after you sign up. If you missed Medicare's Initial Enrollment Period and did not qualify for the Special Open Enrollment Period, you can enroll during the General Enrollment Period.

Special Enrollment Period

If you missed Medicare's Initial Enrollment Period, there are certain situations in which you may qualify for Medicare's Special Enrollment Period, including if you lost coverage through an employer group plan within the last 8 months, lost Medicaid coverage, or because inaccurate or misleading information was provided by your health plan or employer. If you qualify for one of these circumstances, coverage begins on the first of the month after you sign up.

Contact your local Social Security office or visit ***Medicare.gov*** for more information.

SUBMITTING PROOF OF COVERAGE

If you are already collecting Social Security retirement benefits, the Centers for Medicare and Medicaid Services (CMS) will notify the SHBP/SEHBP of your enrollment. This generally requires no additional action on your part unless specifically requested.

If you are retiring from a non-participating location, or receive correspondence from the SHBP/SEHBP requesting proof of your Medicare enrollment just before turning 65, you must enter the proof of enrollment in Medicare for yourself and/or your spouse in Benefitsolver, including the effective dates for Part A and Part B and the Medicare Beneficiary Identifier (MBI) number.

Reinstatement if Terminated

If you and/or your dependent are eligible for Medicare Parts A and B but fail to enroll, your SHBP/SEHBP coverage will be terminated. Once terminated, your coverage will only be reinstated once a letter of confirmation from Social Security, dated within the last 60 days, with your MBI number and effective dates for Medicare Parts A & B is received by the New Jersey Division of Pensions & Benefits (NJDPB). All reinstatements will be processed prospectively.

If you have been terminated due to a lapse in your Medicare Part B premium, you will be reinstated prospectively once you provide proof, as described above, that your Medicare coverage was reinstated, unless a "good faith letter" from Social Security is provided. A good faith letter may apply when you and/or your dependent missed the Initial Enrollment Period due to an error, misrepresentation, or inaction of a federal employee.

Please contact your local Social Security office to obtain or reinstate your Medicare coverage. If you and/or your spouse missed the Initial Enrollment Period, you will have to wait until the next General Enrollment Period unless you qualify for a Special Enrollment Period.

Medicare Part D

Retired members of the SHBP/SEHBP who are enrolled in Medicare are automatically enrolled in the OptumRx Medicare Part D Prescription Drug Plan (PDP).

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 a written request along with proof of other Medicare Part D coverage to the NJDPB.

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 continue.

Note: If you are enrolled in a Medicare Advantage Plan, you can only waive your prescription drug coverage for another group Medicare Part D plan. If you waive coverage for an individual Medicare Part D plan, your SHBP/SEHBP Medicare Advantage Plan will be terminated. 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.

SHBP/SEHBP COSTS AND MEDICARE

It is the SHBP/SEHBP member's responsibility to pay any Medicare premiums due to CMS and the Social Security Administration.

If you are paying the full cost of your SHBP/SEHBP coverage, the SHBP/SEHBP plan cost generally decreases when you and/or your dependents enroll in Medicare Parts A and B because most medical plans charge lower premiums for Medicare-eligible members.

If you qualify in retirement for full or partial payment of your SHBP/SEHBP coverage by the State, you may be eligible for full or partial reimbursement of your Medicare premiums, as follows.

Part B Standard Reimbursement

State Employees and Employees of State Universities/Colleges: The reimbursement of Medicare premiums for retirees of the State or State Universities/Colleges is determined by the terms of the Collective Negotiations Agreement (CNA) in effect when the retiree attained 25 years of service credit. While the reimbursement categories listed below apply to the majority of State retirees, it is important to verify the terms of your applicable CNA with your former employer for any exceptions.

For most State retirees:

If you attained 25 years of service credit after July 1, 1997, any reimbursement of Medicare Part B premiums paid by you and/or your spouse/partner may be limited by the terms of the bargaining unit agreement in place at the time of your retirement or by legislation (Chapter 8) – most State retirees in this group have Medicare Part B reimbursement capped at $46.10.

State employees who began employment after July 1, 1995, who were enrolled prior to July 1, 1995, but had a subsequent break in service, or who became eligible for health benefits after that date, will not be eligible for Medicare Part B reimbursement.

School Board and County College Employees: If you retire with 25 or more years of service credit or on a Disability Retirement, the standard cost of Medicare Part B premiums will be paid by you and/or your spouse/partner and reimbursed.

Local Government Employees: Some employers that adopted P.L. 1999, c. 48 (Chapter 48) or P.L. 1974, c. 88 (Chapter 88), to pay for all or some of the cost of health benefits for retirees under certain conditions, also agreed to reimburse those employees for the Medicare Part B premiums paid by the member and/or their spouse/partner. Check with your employer to determine eligibility for Medicare B reimbursement.

IRMAA Reimbursements

Some individuals pay a surcharge for Medicare Part B and Part D coverage based on their income. This surcharge is the Income Related Monthly Adjustment Amount (IRMAA). The amount of an individual's IRMAA surcharge is based on the Modified Adjusted Gross Income (MAGI) reported to the Internal Revenue Service (IRS) together with their tax filing status. The standard Medicare premiums are increased by the surcharge imposed when the MAGI exceeds certain levels, which are adjusted annually by the IRS.

Medicare uses the MAGI reported on the federal tax return from two years prior to determine the IRMAA surcharge. In addition, the annual *Cost-of-Living Adjustment (COLA) Letter* from the Social Security Administration will indicate if an individual will be subject to the IRMAA surcharge in the upcoming benefit year.

Qualification for IRMAA Reimbursement

Medicare-eligible members of the SHBP/SEHBP may qualify for annual reimbursement of all, or part, of their IRMAA surcharges.

State Employees and Employees of State Universities/Colleges: If you attained 25 or more years of service credited before July 1, 1997, and qualify for full reimbursement of the standard Medicare Part B premium paid by you and/or your spouse, civil union partner, or same-sex domestic partner, you may qualify for IRMAA surcharges paid for Medicare Part B and Part D coverage.

If you attained 25 years of service credit after July 1, 1997, since reimbursement of Medicare Part B premiums paid by you and/or your spouse/partner may be limited by the terms of the bargaining unit agreement in place at the time of your retirement or by legislation, you are not eligible for IRMAA reimbursement for Medicare Part B surcharges. However, you may be eligible for reimbursement of IRMAA surcharges paid for Medicare Part D prescription drug coverage.

State employees who began employment after July 1, 1995, who were enrolled prior to July 1, 1995, but had a subsequent break in service, or who became eligible for health benefits after that date, are not eligible for Medicare Part B reimbursement and therefore not eligible for reimbursement of any IRMAA surcharges.

School Board and County College Employees: If you retired with 25 or more years of service credit or on a Disability Retirement, and receive full reimbursement of the standard Medicare Part B premium paid by you and/or your spouse, civil union partner, or same-sex domestic partner, you may qualify for IRMAA surcharges paid for Medicare Part B and Part D coverage.

Local Government Employees: If you retired from a Local Government employer that adopted P.L. 1999, c. 48 (Chapter 48) or P.L. 1974, c. 88 (Chapter 88), and reimburses you and/or your spouse, civil union partner, or same-sex domestic partner, check with your employer to determine eligibility for any IRMAA reimbursement.

The IRMAA Reimbursement Process

Every February, the NJDPB, through its partner Businessolver, mails notification letters to all Medicare-eligible retirees in the SHBP/SEHBP. Retirees who paid IRMAA surcharges in the prior year for themselves and/or a spouse, civil union partner, or same-sex domestic partner, may apply for reimbursement if they otherwise qualify as previously indicated and in the notification letter.

How to File a Claim

Qualified retirees must submit a claim for IRMAA reimbursement for themselves and/or a qualified spouse, civil union partner, or same-sex domestic partner. Once the IRMAA reimbursement period begins, claims are processed through Benefitsolver and all claims must be submitted before the deadline indicated in the IRMAA reimbursement notification.

- The fastest way to receive reimbursement is through online submission in Benefitsolver through your MyNewJersey account, via ***mynjbenefitshub.nj.gov,*** or with the MyChoice Mobile App.
- Qualified retirees may also fill out an *IRMAA Claim Form* and return it to Businessolver by mail, email, or fax.

Supporting documentation is required along with the online or paper claim form:

- A copy of the *Cost-of-Living Adjustment (COLA) Letter* sent by the Social Security Administration regarding the claim year's Medicare premiums and surcharges; and
- A copy of the first two pages of your federal income-tax return for the year preceding the claim year.

You must also include proof of payment for all months that you were eligible for reimbursement. Proof of payment can be one or a combination of the following:

- A copy of your Social Security *Form SSA-1099;* or
- A copy of your *Form RRB-1099* (if in the Railroad Retirement system).

If you did not receive *Form SSA-1099,* you can submit alternative proof of your Medicare Part B or D payments:

- Your Medicare Premium Bill; and
- The ***Medicare.gov*** Payment History.

Note: Retirees who did not pay IRMAA surcharges for Medicare Part B and Part D coverage in the prior year are not eligible for any IRMAA reimbursement and should not apply.

Claim Processing

All claims must be submitted before the deadline indicated in the IRMAA reimbursement notification.

To ensure your claim is complete and can be processed as quickly as possible, provide all information requested for the claim along with the supporting documentation.

If submitting your claim online: Supporting documentation can be uploaded in Benefitsolver through your MyNewJersey account, via ***mynjbenefitshub.nj.gov****,* or with the MyChoice Mobile App.

If submitting your claim by mail: Supporting documentation should be sent to the address indicated on the *IRMAA Claim Form.*

Note: Claim information should not be sent to the NJDPB.

If any of the required documentation or information is missing, your claim will not be complete and may be delayed in processing. If the claim is denied due to missing or incomplete information, qualified retirees have up to one year from the claim submission deadline to provide the required documents. Late documents will not be accepted and reimbursements cannot be made more than one year after the IRMAA claim deadline.

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SHBP/SEHBP MEDICARE PART A HOSPITAL INSURANCE FOR CALENDAR YEAR 2026

SERVICE	BENEFIT	MEDICARE PAYS	AETNA MEDICARE ADVANTAGE PLANS Aetna Freedom 10 Aetna Freedom 15 Aetna HMO Aetna HMO 1525	HORIZON MEDICARE SUPPLEMENT PLANS IN-NETWORK Horizon NJ DIRECT 1525 Horizon NJ DIRECT 2030 Horizon HMO Horizon HMO 1525 Horizon HMO 2030	HORIZON MEDICARE SUPPLEMENT PLANS OUT-OF-NETWORK Horizon NJ DIRECT 1525 Horizon NJ DIRECT 2030
Hospitalization — Semi-private room and board; including routine general nursing care, operating and recovery rooms, anesthesia, X-rays, lab tests, oxygen, drugs, and dressings.	First 60 days.	All but $1,600.	100% of eligible charges.	All eligible charges not covered by Medicare.	After a $200 deductible per hospital stay[2] ($500 for NJ DIRECT 2030) NJ DIRECT 1525 and 2030 pay 70% of eligible charges not covered by Medicare, subject to the annual maximum.
	61st through 90th day.	All but $400 per day.			
	91st through 150th day.	All but $800 per day.			
	After 150th day.	Nothing.			
Post-Hospital Skilled Nursing Facility Care — This is not nursing home care. Services include room and board, routine nursing care, and physical, occupational, and speech therapies.	First 20 days.	100% of approved amount.	100% of eligible charges.	N/A (covered by Medicare)	N/A (covered by Medicare)
	21st through 100th day.	All but $200.00 per day.	100% of eligible charges.	All eligible charges not covered by Medicare.	After $200 deductible, NJ DIRECT 1525 and 2030 pay 70% of eligible charges not covered by Medicare; up to 60 days to annual maximum, after 60 days — nothing.
	After 100th day.	Nothing.	100% of eligible charges through the 120th day.	Precertification required based on Horizon BCBSNJ review of medical appropriateness and eligibility.	
Hospice Care — Nursing care, physician services, counseling services, respite care, medical applications and supplies, short-term inpatient care, health aide services, and homemaker services.	Covered if doctor certifies need.	All but limited cost per outpatient prescription drugs and inpatient respite care. Inpatient room and board services are generally not covered.	Prescription Drugs for symptom control and pain relief, short-term respite care, and home care are covered from any Medicare-certified hospice program. Hospice doctor can be in- or out-of-network provider.	Eligible charges not covered by Medicare, including prescription drugs, respite care, and inpatient room and board.	After $200 deductible, NJ DIRECT 1525 and 2030 pay 70% of eligible charges not covered by Medicare, including outpatient prescription drugs, inpatient respite care, and inpatient room and board.

SHBP/SEHBP MEDICARE PART B MEDICAL INSURANCE FOR CALENDAR YEAR 2026

SERVICE	MEDICARE PAYS	AETNA MEDICARE ADVANTAGE PLANS Aetna Freedom 10 Aetna Freedom 15 Aetna HMO Aetna HMO 1525	HORIZON MEDICARE SUPPLEMENT PLANS IN-NETWORK Horizon NJ DIRECT 1525 Horizon NJ DIRECT 2030 Horizon HMO Horizon HMO 1525 Horizon HMO 2030	HORIZON MEDICARE SUPPLEMENT PLANS OUT-OF-NETWORK Horizon NJ DIRECT 1525 Horizon NJ DIRECT 2030
Medical Expenses — Physician's care, including surgeon's and assistant surgeon's fees.	80% of approved amount after $226 Medicare deductible.	100% of eligible charges subject to plan copayments.	100% of eligible charges not covered by Medicare subject to plan copayments.	After deductible NJ DIRECT 1525 pay 70% of eligible charges not covered by Medicare (subject to reasonable and customary charges[1]).
Outpatient Mental Health Services	80% of approved amount.	100% of eligible charges subject to plan copayments.	NJ DIRECT covers 100% of eligible charges subject to plan copayments.	After deductible NJ DIRECT 1525 and 2030 pay 70% of eligible charges not covered by Medicare (subject to reasonable and customary charges[1]).
Durable Medical Equipment	Full cost of services. 80% of approved amount.	100% of eligible charges.	NJ DIRECT — covered at 90% of eligible charges not covered by Medicare. Horizon HMO — covered at 100% after $100 deductible.	After deductible NJ DIRECT 1525 and 2030 and pay 70% of eligible charges not covered by Medicare (subject to reasonable and customary charges[1]).

Note: Provider must accept Medicare for any of these services to be eligible for payment.

[1] Annual Maximum out-of-pocket expenses for coinsurance for all eligible charges is $2,000 per individual for NJ DIRECT 1525 and Freedom 1525, and $5,000 for NJ DIRECT 2030 and Freedom 2030.

Note: The standard Part B premium amount in 2026 will be $202.90 per month. Your costs may be higher depending on your income. Social Security will tell you the exact amount you will pay for Part B in 2026, which is based on several factors: income; the timeliness of application for Part B; and the date when deductions began for Part B. For more information about premiums, call Social Security at 1-800-772-1213 or visit the Centers for Medicare & Medicaid Services website.