

## STATE HEALTH BENEFITS PROGRAM (SHBP)

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

Coverage Period: 01/01/2027 – 12/31/2027

Retired Rx: State/Local Government HMO2030 and PPO2030



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> ? | <b>\$1,351</b> individual/ <b>\$2,702</b> 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<br>(You will pay the least)                                                                                               | Out-of-Network Provider<br>(You will pay the most)                                     |                                                                                                              |
| If you visit a health care <u>provider's</u> 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.                                                                               |
|                                                                                                                                                                                                                          | <u>Specialist</u> visit<br><u>Preventive care/screening</u> /immunization |                                                                                                                                            |                                                                                        |                                                                                                              |
| If you have a test                                                                                                                                                                                                       | <u>Diagnostic test</u> (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<br>More information about <u>prescription drug coverage</u> 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<br>\$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.                                                                   |
|                                                                                                                                                                                                                          | Preferred Brand drugs                                                     | \$18 copay/1-30 day supply \$36 / 31-60 day supply \$54 / 61-90 day supply at a retail pharmacy<br>\$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 \$138 / 61-90 day supply at a retail pharmacy<br>\$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                           | Non-Medicare members pay the applicable brand copayment as listed above, plus the                                                          | 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. |

| Common Medical Event | Services You May Need           | What You Will Pay                                                       |                                                    | Limitations, Exceptions, & Other Important Information                                       |
|----------------------|---------------------------------|-------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------|
|                      |                                 | Network Provider<br>(You will pay the least)                            | Out-of-Network Provider<br>(You will pay the most) |                                                                                              |
|                      |                                 | cost difference between the brand drug and the generic drug if covered. |                                                    |                                                                                              |
|                      | <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>        |                                |                                |                                |
| <b>If your child needs dental or eye care</b>                                    | <a href="#">Hospice services</a>                 |                                |                                |                                |
|                                                                                  | 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](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.

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

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0 |
| ■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]            | n/a |
| ■ Hospital (facility) [ <i>cost sharing</i> ]                   | n/a |
| ■ Other [ <i>cost sharing</i> ]                                 | 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> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

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

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                                                 |     |
|-----------------------------------------------------------------|-----|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0 |
| ■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]            | n/a |
| ■ Hospital (facility) [ <i>cost sharing</i> ]                   | n/a |
| ■ Other [ <i>cost sharing</i> ]                                 | 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> |
|---------------------------|----------------|

#### 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0 |
| ■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]            | n/a |
| ■ Hospital (facility) [ <i>cost sharing</i> ]                   | n/a |
| ■ Other [ <i>cost sharing</i> ]                                 | 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> |
|---------------------------|----------------|

#### 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.

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