


# SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM (SEHBP)


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

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

Rx thru Health Plan: NJ EDUCATORS HEALTH PLAN 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> ? | \$1,600 individual/ \$3,200 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 <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<br><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<br>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  | \$5 copay/1-30 day supply \$10 / 31-60 day supply \$15 / 61-90 day supply at a retail pharmacy<br>\$10 copay/90 day supply    | 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<br>\$20 copay/90 day supply     | 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 the brand drug and the generic drug. | 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. |
|   | <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.                 |

| 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 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                           |  |  |  |
| If you need immediate medical attention                                   | <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>                      |  |  |  |
| 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            | <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>  |  |  |  |  |
| 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](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> |
|---------------------------|-----------------|

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        |
| <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> |
|---------------------------|----------------|

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        |
| <b>The total Joe would pay is</b> | <b>\$2,010</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> |
|---------------------------|----------------|

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        |
| <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.