Health Benefit Plan Comparison
2025-26

Note: This comparison is for informational purposes only. In case of conflict between any of the benefits of this comparison and the Plan Document (SPD), the benefits of the Plan Document shall control.

		TRBOE PPO-A	TRBOE-PPO-B	TRS EHP	TRS GSP
					COVERAGE LIMITED TO NJ BASED PROVIDERS ONLY
IN-NETWORK	Deductible (Single/Family)	$200 / $400	Not Applicable	Not Applicable	Not Applicable
	Coinsurance	20% *1	Not Applicable	10% *2	INN Covered 100%
	Primary Care Physician Copayment	$10	$5	$10	$10
	Specialist Copayment	$10	$5	$15	$15
	Emergency Room Copayment	No Charge	$25 Copay / Visit	$125	$125
	Out-of-Pocket Maximum (Single/Family)	$400 / $800	$400 / $1000	$500/$1,000	$500/$1,000
	Inpatient Hospitalization	No Charge	No Charge	No Charge	No Charge
	PHC Access	YES	YES	YES	YES
OUT-OF-NETWORK	Deductible (Single/Family)	$200 / $400	$300 / $600	$350/$700	$350/$700
	Out-of-Network Coinsurance	20%	30%	30%	30%
	Out-of-Pocket Maximum (Single/Family)	$400 / $800	$2,000 / $5,000	$2,000/$5,000	$2,000/$5,000
	Inpatient Hospitalization	20% Coinsurance	30% Coinsurance	30%	30% after deductible
	Maximum Provider Reimbursement	Usual and Customary (80% of FAIR Health)	Usual and Customary (80% of FAIR Health)	200% of CMS - Medicare	200% of CMS - Medicare
PRESCRIPTION DRUG	Out-of-pocket limit (Single/Family)	$6,450 / $12,700	$6,450 / $12,700	$1,600 / $3,200	$1,600 / $3,200
	Retail – Generic	$3 (30 day supply) $6 (60 day supply) $9 (90 day supply)	$3 (30 day supply) $6 (60 day supply) $9 (90 day supply)	$5 (30 day supply) $10 (60 day supply) $15 (90 day supply)	$5 (30 day supply) $10 (60 day supply) $15 (90 day supply)
	Retail – Brand w/ No Generic Available	$10 (30 day supply) $20 (60 day supply) $30 (90 day supply)	$10 (30 day supply) $20 (60 day supply) $30 (90 day supply)	$10 (30 day supply) $20 (60 day supply) $30 (90 day supply)	$10 (30 day supply) $20 (60 day supply) $30 (90 day supply)
	Retail – Brand w/ Generic Available	n/a - no mandatory generic	n/a - no mandatory generic	Member pays the difference *3	Member pays the difference *3
	Mail – Generic	$5	$5	$10 (90 day supply)	$10 (90 day supply)
	Mail – Brand w/ No Generic Available	$15	$15	$20 (90 day supply)	$20 (90 day supply)
	Mail – Brand w/ Generic Equivalent	n/a - no mandatory generic	n/a - no mandatory generic	Member pays the difference *3	Member pays the difference *3
ADDITIONAL BENEFITS COVERAGE INFORMATION	Physical Therapy / Habilitation Services Outpatient Short-Term Rehabilitation	$10 Copay / Visit (OON 20% Coinsurance)	$5 Copay / Visit (OON 30% Coinsurance)	$15 copay (OON 30%; after deductible for speech and occupational therapy. Lesser of $52/visit or 75% of in-network cost/visit for physical therapy)	$15 copay (OON 30%; after deductible for speech and occupational therapy. Lesser of $52/visit or 75% of in-network cost/visit for physical therapy)
	Chiropractic Care	$10 Copay, then 100% (OON 20% Coinsurance) some bargaining units subject to annual cap	$5 Copay / Visit (OON 30% Coinsurance) some bargaining units subject to annual cap	$15 Copay (OON $35/visit or 75% of the in-network cost per visit, whichever is less.)	$15 Copay (OON $35/visit or 75% of the in-network cost per visit, whichever is less.)
	Acupuncture	$10 Copay, then 100% (OON 20% Coinsurance) some bargaining units subject to annual cap	$5 Copay / Visit (OON 30% Coinsurance) some bargaining units subject to annual cap	$15 Copay (OON Lesser of $60/visit or 75% of in network cost/visit)	$15 Copay (OON Lesser of $60/visit or 75% of in network cost/visit)
	Routine Lab: Diagnostic test (x-ray, blood work); Imaging (CT/PET scans, MRIs)	No Charge (OON 20% Coinsurance)	No Charge (OON 30% Coinsurance)	No Charge (OON 30% Coinsurance)	No Charge (OON 30% Coinsurance)
	Preventive care / screening / immunization	No Charge (OON 20% Coinsurance)	No Charge (OON 30% Coinsurance)	No Charge (OON Not Covered)	No Charge (OON Not Covered)
	If you have outpatient surgery: ***Facility fee (e.g. ambulatory surgery center)***	No Charge (OON 20% Coinsurance)	No Charge (OON 30% Coinsurance)	No Charge (OON 30% Coinsurance)	No Charge (OON 30% Coinsurance)
	If you have outpatient surgery: ***Physician / surgeon fees***	No Charge (OON 20% Coinsurance)	No Charge (OON 30% Coinsurance)	No Charge (OON 30% Coinsurance)	No Charge (OON 30% Coinsurance)
	If you need immediate medical attention: ***Emergency medical transportation***	20% Coinsurance (emergency services and non-emergency services)	No Charge (emergency services and non-emergency services)	10% Coinsurance (OON 30% Coinsurance)	10% Coinsurance (OON same as INN care)
	If you need immediate medical attention: ***Urgent Care***	$10 Copay / Visit (OON 20% Coinsurance)	$5 Copay / Visit (OON 30% Coinsurance)	$15 Copayment per visit (OON 30% Coinsurance)	$15 Copayment per visit (OON 30% Coinsurance)
	If you need mental health, behavioral health, or substance abuse services: ***Outpatient services***	$10 Copay / Visit (office visit)/ No Charge (all other outpatient) (OON 20% Coinsurance)	$5 Copay / Visit (office visit)/ No Charge (all other outpatient) (OON 30% Coinsurance)	No Charge for Outpatient Hospital or Substance Abuse Office Visit. $15 Copay / visit for Mental Health and Behavioral Health.(OON 30% Coinsurance for Outpatient Hospital.)	$15 Copay / visit for Mental Health and Behavioral Health. (OON 30% Coinsurance for Outpatient Hospital.)
	If you need mental health, behavioral health, or substance abuse services: ***Inpatient services***	No Charge (OON 20% Coinsurance)	No Charge (OON 30% Coinsurance)	No Charge for Inpatient Hospital (OON 30% Coinsurance)	No Charge for Inpatient Hospital (OON 30% Coinsurance)
	If you are pregnant: ***Office Visits***	No Charge (OON 20% Coinsurance)	No Charge (OON 30% Coinsurance)	$10.00 Copayment per visit for Office. $15.00 Copayment per visit for Office; Specialist. (OON 30% Coinsurance)	$10.00 Copayment per visit for Office. $15.00 Copayment per visit for Office; Specialist. (OON 30% Coinsurance)
	If you are pregnant: ***Childbirth/delivery professional services***	No Charge (OON 20% Coinsurance)	No Charge (OON 30% Coinsurance)	No Charge (OON 30% Coinsurance)	No Charge (OON 30% Coinsurance)
	If you are pregnant: ***Childbirth/delivery facility services***	No Charge (OON 20% Coinsurance)	No Charge (OON 30% Coinsurance)	No Charge (OON 30% Coinsurance)	No Charge (OON 30% Coinsurance)
	If you need help recovering or have other special health needs: ***Home health care***	No Charge *(OON 20% Coinsurance)*	No Charge *(OON 30% Coinsurance)*	No Charge (OON 30% Coinsurance)	No Charge (OON 30% Coinsurance) *Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.*

If you need help recovering or have other special health needs: ***Rehabilitation services***	$10 Copay / Visit *(OON 20% Coinsurance)*	$5 Copay / Visit *(OON 30% Coinsurance)*	No Charge for Inpatient and Outpatient Facility $15 Copay / Office visit (OON 30% Coinsurance)	$15 Copay / Office visit (OON 30% Coinsurance) *Lesser of $52/visit or 75% of in-network cost/visit for physical therapy only*
If you need help recovering or have other special health needs: ***Habilitation services***	$10 Copay / Visit *(OON 20% Coinsurance)*	$5 Copay / Visit *(OON 30% Coinsurance)*	No Charge for Inpatient and Outpatient Facility $15 Copay / Office visit (OON 30% Coinsurance)	$15 Copay / Office visit *(OON 30% Coinsurance)*
If you need help recovering or have other special health needs: ***Skilled nursing care***	No Charge *(OON 20% Coinsurance)*	No Charge *(OON 30% Coinsurance)*	No Charge (OON 30% Coinsurance) Limited to 120 days in-network and 60 out-of- network facility days for a combined maximum of 120 days per calendar year.	No Charge (OON 30% Coinsurance) Limited to 120 days in-network and 60 out-of- network facility days for a combined maximum of 120 days per calendar year.
If you need help recovering or have other special health needs: ***Durable medical equipment***	20% Coinsurance *(OON 20% Coinsurance)*	No Charge *(OON 30% Coinsurance)*	10% Coinsurance (OON 30% Coinsurance)	10% Coinsurance (OON 30% Coinsurance)
If you need help recovering or have other special health needs: ***Hospice services***	No Charge *(OON 20% Coinsurance)*	No Charge *(OON 30% Coinsurance)*	No Charge (OON 30% Coinsurance)	No Charge (OON 30% Coinsurance)
Children's Eye Exam	Not Covered	Not Covered	$15 Copay / Office visit (OON not covered)	$15 Copay / Office visit (OON not covered)

**1 - Member is responsible for 20% of eligible charges after applicable deductibles are met specific to: Ambulance Services (both Emergency and Non-Emergency Medical Condition or Medically Necessary Transfer); Diabetic Education and supplies; Durable Medical Equipment; Foot Orthotics; Hearing Aids and related supplies (up to 16); Private Duty Nursing (outpatient).*

**2 - Member is responsible for 10% of eligible charges after applicable Deductibles are met specific to: Ambulance Services (Emergency Medical transportation limited to local emergency transport to the nearest facility equipped to treat the emergency condition); and Durable Medical Equipment.*

**3- Member pays difference in cost between generic and brand, plus brand copayment.*