NJ State Health Benefits Program (SHBP)

State and State College/University Employees



HorizonBlue.com/shbp 1-800-414-7427

2024

OVERVIEW







At Horizon, we're guiding members to achieve their best health.

For more than 90 years, Horizon has helped New Jersey residents get the most out of their health care coverage. As a leader in providing access to quality, affordable health plans, we offer an extensive provider network to ensure you're cared for whenever, wherever. We keep things simple – every New Jersey hospital is in our network. Plus, we provide tools and support that make navigating health care easier.

Health and wellness for mind and body.

Education Resources

Get tips for healthier living with our wide range of online health education topics.

Pregnancy Resources

PRECIOUS ADDITIONS® offers personalized support and interactive resources during pregnancy and beyond – including My Pregnancy Assistant, an online tool powered by WebMD®.

Health Management Tools

Manage your health and track your progress securely and confidentially with the digital coaching and customized tools of *MyHealth Manager*, powered by WebMD.

Horizon*b*Fit^s™

Eligible SHBP members may receive a \$20 reward¹ for every month they visit a fitness facility, walk 10,000+ steps or complete certain workouts for at least 12 days a month.

Wellness Discounts

With Blue365[®], get weekly email deals from top retailers, including gym memberships, nutrition programs, glasses, contacts and more.

YMCA Discount²

Get a 15% discount on monthly memberships at participating New Jersey YMCAs – plus, new YMCA members can have their initiation fee waived. <u>HorizonBlue.com/ymca</u>

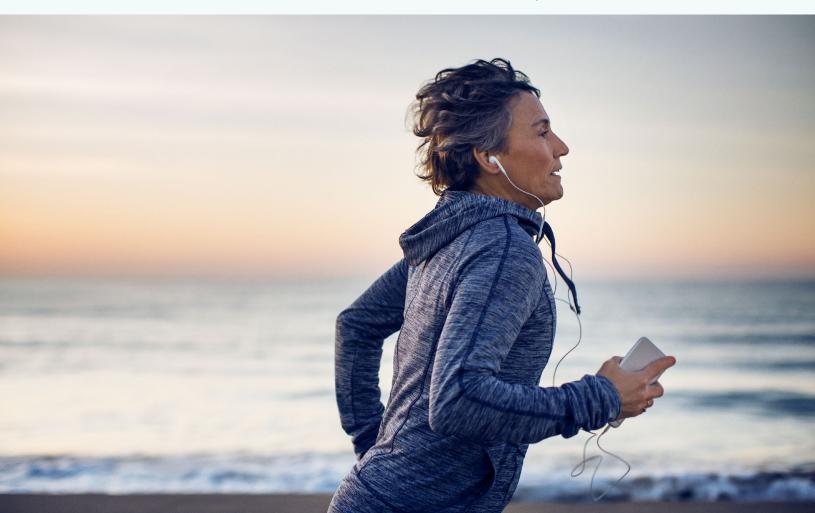
Walgreens Discount²

SHBP members are eligble for 30% off Walgreensbranded health and wellness products every time they shop in store, online or through the Walgreens app. <u>HorizonBlue.com/walgreens</u>

1. Rewards are taxable.

2. Restrictions and limitations apply. For more information, please visit the associated website links above. Walgreens discounts available as of July 1, 2024.

Learn more at HorizonBlue.com/shbp





Achieve your best health and earn rewards.

The NJWELL program is a great way to make meaningful changes to your wellness habits with program enhancements for eligible members and their covered spouse/partner. NJWELL can help you achieve holistic well-being including:

- Physical fitness
- Emotional balance
- Preventive care
- Social connection
- Financial security

Learn more about NJWELL at <u>HorizonBlue.com/shbp/njwell</u> or visit the NJ Division of Pensions and Benefits website at <u>nj.gov/treasury/pensions</u>.



You can earn \$250 or more in rewards* each wellness year (November 1 to October 31).

Rewards are taxable.



Our best coverage, for your best you.

OMNIAsm Health Plan

In addition to having some of our best benefits, our OMNIA Health Plan Option gives you the flexibility to choose from one of New Jersey's largest networks: 70,000+ local doctors, specialists and health professionals and 95 hospitals in 115 convenient locations across New Jersey and parts of Pennsylvania and Delaware.* You also have worldwide access to more than 2 million providers in our BlueCard® PPO program.

To save even more, choose from more than 49,000 OMNIA Tier 1 doctors* and some of the state's leading hospitals for lower copayments, lower out-of-pocket costs and no deductibles – all with no referrals and no need to choose a Primary Care Physician (PCP).

*Based on Horizon provider network data as of 10/23 and is subject to change.

PPO Plans

All of our PPO plans include:

- Care in network or out of network in New Jersey, nationwide and abroad
- No need to select a PCP
- No referrals necessary to see a specialist
- Lower out-of-pocket costs when using the Horizon Managed Care Network or the BlueCard PPO Network nationwide and Blue Cross Blue Shield Global® Core abroad

High Deductible PPO Plans

NJ DIRECT High Deductible Health Plans (HDHPs) combine a high deductible health plan with a health savings account (HSA). Eligible preventive services are covered at 100 percent if in network and do not have a deductible. You are responsible for eligible medical and prescription expenses, up to the deductible.

HMO Plans

With our HMO plans, you have access to health care professionals and facilities in the Horizon Managed Care Network in New Jersey and parts of New York, Pennsylvania and Delaware. You select a licensed PCP from the Horizon Managed Care Network and your PCP will refer you to specialty care when needed. In addition, the Away From Home Care Program is available to eligible HMO members who are outside the State of New Jersey, like students living away from home, long-term travelers and families living apart.



Active employees: Calculate your estimated premium contribution at <u>HorizonBlue.com/shbp</u>.



2024 NJ SHBP State and State College/University Employees **Plans for CWA and Union Negotiated Members**



Plans effective 7/1/2024 (effective 6/29/2024 for biweekly employees)

HorizonBlue.com/shbp 1-800-414-SHBP (7427)	OMNIA Tiered Network Plan OMNIA HEALTH PLAN		
	Tier 1	Tier 2	
IN-NETWORK (IN)			
Service Area Available	NJ only	Nationwide	
Specialist Referral	No referral required	No referral required	
Deductible ²			
Individual	\$0	\$1,500	
Family	\$0	\$3,000	
Coinsurance	0%	20% after deductible	
Coinsurance Out-of-Pocket Maximum			
Individual	Not applicable	Not applicable	
Family	Not applicable	Not applicable	
Total Out-of-Pocket Maximum (Copay+Deductible+Coinsurance)			
Individual	\$2,500	\$4,500	
Family	\$5,000	\$9,000	
HEALTH CARE SERVICES			
Primary Care Office Visit	\$5	\$20	
Annual Routine Physical (In-Network Only)	\$0	\$0	
Direct Primary Care (DPC) Doctors Office	\$0	\$0	
First Responders Doctors Office (FRDOCS)	\$0	\$0	
Horizon CareOnline (Telemedicine)	Cost share may apply	Cost share may apply	
Specialist Office Visit	\$20	\$35	
Annual Routine Vision (In-Network Only)	\$20	\$35	
Chiropractic⁵	\$20	\$35	
Physical/Occupational/Speech Therapy ⁶	\$20 office visit/\$20 outpatient facility \$35 office visit/ 20% after deductible at an outpatier		
DIAGNOSTIC LABORATORY7/RADIOLOGY/ADVANCED IMAGING			
Outpatient Laboratory/Radiology/Advanced Imaging	\$20	20% after deductible	
Freestanding Laboratory/Radiology/Advanced Imaging	\$0	\$0	
EMERGENCY/URGENT MEDICAL SERVICES			
Urgent Care Center	\$35	\$50	
Emergency Room	\$100	\$100	
Ambulance	\$0	\$0	
OTHER SERVICES			
Inpatient Facility	\$150 per admission ⁹	20% after deductible	
Outpatient Facility	\$150	20% after deductible	
Outpatient Behavioral Health	\$20	\$35 office visit/ 20% after deductible at an outpatient facility	
Durable Medical Equipment (DME)	\$0	\$0	
OUT-OF-NETWORK (OON) ¹⁰			
Deductible - Individual			
Deductible - Family			
Coinsurance after Deductible			
Coinsurance after Deductible	NI	f-network benefits	
	INO OUT-O		
Out-of-Pocket Coinsurance Maximum - Individual Out-of-Pocket Coinsurance Maximum - Family	No out-o		

1. High Deductible Health Plan. NJ DIRECT HDLow plan includes \$300 Health Savings Account funding by employer.

Deductible applies to all services that require a coinsurance.
 Includes eligible prescription cost share.

 ^{4.} On select any other and a digit of the selection of the se Laboratory services must be rendered by an in-network participating provider, with some exceptions based on medical policy.
 Lower copayment applies to children under 19 and physician referrals.
 \$150 per admission does not apply to inpatient childbirth, hospice or inpatient behavioral health/substance use disorder.

2024 NJ SHBP State and State College/University Employees Plans for CWA and Union Negotiated Members



Plans effective 7/1/2024 (effective 6/29/2024 for biweekly employees)

HorizonBlue.com/shbp 1-800-414-SHBP (7427)	PPO	Plans	High Deductible PPO Plan	
	CWA UNITY DIRECT NJ DIRECT (employees hired prior to 7/1/19)	CWA UNITY DIRECT2019 NJ DIRECT2019 (new hires on or after 7/1/19)	NJ DIRECT HDLow ¹	
IN-NETWORK (IN)				
Service Area Available	Nationwide	Nationwide	Nationwide	
Specialist Referral	No referral required	No referral required	No referral required	
Deductible ²				
Individual	\$0	\$100	\$1,600 ³	
Family	\$0	Not applicable	\$3,200 ³	
Coinsurance	10%4	10% after deductible ⁴	20% after deductible ³	
Coinsurance Out-of-Pocket Maximum				
Individual	\$800	\$800	\$1,000	
Family	\$2,000	\$2,000	\$2,000	
Total Out-of-Pocket Maximum (Copay+Deductible+Coinsurance)				
Individual	\$7,560	\$7,560	\$2,600 ³	
Family	\$15,120	\$15,120	\$5,200 ³	
HEALTH CARE SERVICES				
Primary Care Office Visit	\$15	\$15	20% after deductible	
Annual Routine Physical (In-Network Only)	\$0	\$0	\$O	
Direct Primary Care (DPC) Doctors Office	\$0	\$0	Not available	
First Responders Doctors Office (FRDOCS)	\$0	\$0	\$0	
Horizon CareOnline (Telemedicine)	Cost share may apply	Cost share may apply	Cost share may apply	
Specialist Office Visit	\$30	\$30	20% after deductible	
Annual Routine Vision (In-Network Only)	\$30	\$30	20% after deductible	
Chiropractic ⁵	\$30	\$30	20% after deductible	
Physical/Occupational/Speech Therapy ⁶	\$30	\$30	20% after deductible	
DIAGNOSTIC LABORATORY7/RADIOLOGY/ADVANCED IMAGING				
Outpatient Laboratory/Radiology/Advanced Imaging	\$0	\$0	20% after deductible	
Freestanding Laboratory/Radiology/Advanced Imaging	\$0	\$0	20% after deductible	
EMERGENCY/URGENT MEDICAL SERVICES				
Urgent Care Center	\$45	\$45	20% after deductible	
Emergency Room	\$150 ⁸	\$150 ⁸	20% after deductible	
Ambulance	10%	10% after deductible	20% after deductible	
OTHER SERVICES				
Inpatient Facility	\$0	\$0	20% after deductible	
Outpatient Facility	\$0	\$0	20% after deductible	
Outpatient Behavioral Health	\$30	\$30	20% after deductible	
Durable Medical Equipment (DME)	10%	10% after deductible	20% after deductible	
OUT-OF-NETWORK (OON) ¹⁰				
Deductible - Individual	\$400	\$400	See in-network deductible ¹¹	
Deductible - Family	\$1,000	\$1,000	See in-network deductible ¹¹	
Coinsurance after Deductible	30%	30%	40%	
Out-of-Pocket Coinsurance Maximum - Individual	\$2,000	\$2,000	\$3,600	
Out-of-Pocket Coinsurance Maximum - Family	\$5,000	\$5,000	\$7,200	

10. Out-of-network cost basis: CWA Unity DIRECT, CWA Unity DIRECT2019, NJ DIRECT and NJ DIRECT2019: 175% of CMS (Centers for Medicare & Medicaid Services) fee schedule. NJ DIRECT HD plans: 90th percentile of FAIR Health national benchmark. All plans with an out-of-network benefit also have specified dollar limits for out-of-network chiropractic (\$35), physical therapy (\$52) and acupuncture (\$60).

11. Out-of-network deductible is combined with in-network deductible.

This is not a complete list of all covered services. Exclusions and limitations apply to some services. Visit <u>nj.gov/treasury/pensions/member-guidebooks.shtml</u> for more information. You can reference <u>HorizonBlue.com/shbp</u> to determine your premium contribution.

Horizon Dental Choice plan available. Please visit <u>HorizonBlue.com/shbp</u>.

Retirees: Please visit nj.gov/treasury/pensions for information regarding available retiree plans.

This document is for informational purposes only and does not constitute a binding agreement. The information provided by this document is not intended to replace or modify the terms, conditions, limitations and exclusions contained within health plans issued or administered by Horizon. In the event of a conflict between the information contained in this document and your plan documents, your plan documents shall control.

2024 NJ SHBP State and State College/University Employees Plans for CWA and Union Negotiated Members



Plans effective 7/1/2024 (effective 6/29/2024 for biweekly employees)

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Direct Primary Care (DPC) Doctors Office Not available Not available First Responders Doctors Office (FRDOCS) \$0 \$0 Horizon CareOnline (Telemendicine) Cost share may apply Cost share may apply Specialist Office Visit 20% after deductible \$30 Annual Routine Vision (In-Network Only) 20% after deductible \$30 Chiropractic ³ 20% after deductible \$30 Physical/Occupational/Speech Therapy ⁴ 20% after deductible \$30 DIAGNOSTIC LABORATORY//RADIOLOGY/ADVANCED IMAGINO U U Outpatient Laboratory/Radiology/Advanced Imaging 20% after deductible \$0 Outpatient Laboratory/Radiology/Advanced Imaging 20% after deductible \$0 Creater 20% after deductible \$100 ⁴ Concenter 20% after deductible \$100 ⁴ Renegency Room 20% after deductible \$0 Outpatient Eachity 20% after deductible \$0 Outpatient Bachity 20% after deductible \$0 Outpatient Bachity 20% after deductible \$0 Outpatient Bachity 20% after	Primary Care Office Visit	20% after deductible	\$15	
First Responders Doctors Office (FRDOCS) \$0 \$0 Horizon CareOnline (Telemedicine) Cost share may apply Cost share may apply Specialist Office Visit 20% after deductible \$30 Annual Routine Vision (In-Network Only) 20% after deductible \$30 Chiropractic* 20% after deductible \$30 Physical/Occupational/Speech Therapy* 20% after deductible \$30 DIACNOSTIC LABORATORY/RADIOLOGY/ADVANCED IMAGING 50 50 Diatational Laboratory/Radiology/Advanced Imaging 20% after deductible \$0 Presetanding Laboratory/Radiology/Advanced Imaging 20% after deductible \$0 Emergency Room 20% after deductible \$0 Annualnec 20% after deductible \$100 ^a Anbulance 20% after deductible \$100 ^a Outpatient Facility 20% after deductible \$0 Outpatient Facility 20	Annual Routine Physical (In-Network Only)	\$0	\$0	
Horizon CareOnline (Telemedicine)Cost share may applyCost share may applySpecialist Office Visit20% after deductible\$30Annual Routine Vision (In-Network Only)20% after deductible\$30Chiropractic*20% after deductible\$30Physical/Occupational/Speech Therapy*20% after deductible\$30DIAGNOSTIC LABORATORY/RADIOLOGY/ADVANCED IMAGINGOutpatient Laboratory/Radiology/Advanced Imaging20% after deductible\$0Prestanding Laboratory/Radiology/Advanced Imaging20% after deductible\$0EMERGENCY/URGENT MEDICAL SERVICESUrgent Care Center20% after deductible\$100°Ambulance20% after deductible\$100°Outpatient Facility20% after deductible\$0Outpatient Behavioral Health\$0\$0Outpatient Facility\$0% after deductible\$100 deductible, then covered in fullOutpatient Behavioral Health\$0% after deductible*\$100 deductible, then covered in fullOutpatient Behavioral Health\$0% after deductible*\$100 deductible, then covered in fullOutpatient Behavioral Health\$6% non-metwork deductible*\$100 deductible health	Direct Primary Care (DPC) Doctors Office	Not available	Not available	
Specialist Office Visit 20% after deductible 530 Annual Routine Vision (In-Network Only) 20% after deductible 530 Chiropractic ² 20% after deductible 530 Physical/Occupational/Speech Therapy ⁴ 20% after deductible 530 DIAGNOSTIC LABORATORY//RADIOLOGY/ADVANCED IMAGING V V Outpatient Laboratory/Radiology/Advanced Imaging 20% after deductible 50 Chiropractic S0 V V Outpatient Laboratory/Radiology/Advanced Imaging 20% after deductible 50 Chiropractic S0 V V Urgent Care Center 20% after deductible 5100 ⁴ Emergency Room 20% after deductible 50 Other Facility 20% after deductible 50 Outpatient Facility 20% after deductible 50	First Responders Doctors Office (FRDOCS)	\$0	\$0	
Annual Routine Vision (In-Network Only)20% after deductible\$30Chiropractic 320% after deductible\$30Physical/Occupational/Speech Therapy*20% after deductible\$30DIAGNOSTIC LABORATORY//RADIOLOGY/ADVANCED IMAGING\$30DUtpatient Laboratory/Radiology/Advanced Imaging20% after deductible\$0Cottpatient Laboratory/Radiology/Advanced Imaging20% after deductible\$0CMERENCY/URGENT MEDICAL SERVICESImage: Constraint of the service of	Horizon CareOnline (Telemedicine)	Cost share may apply	Cost share may apply	
Chiropractic*20% after deductible30Physical/Occupational/Speech Therapy*20% after deductible30DIAGNOSTIC LABORATORY/RADIOLOGY/ADVANCED IMAGING00Outpatient Laboratory/Radiology/Advanced Imaging20% after deductible50Freestanding Laboratory/Radiology/Advanced Imaging20% after deductible50EMERGENCY/URGENT MEDICAL SERVICESU0Urgent Care Center20% after deductible\$45Emergency Room20% after deductible\$100*Ambulance20% after deductible\$0OTHER SERVICESU0Ungent Facility20% after deductible\$0Outpatient Facility20% after deductible\$0Outpatient Facility20% after deductible\$0Outpatient Behavioral Health20% after deductible\$0Outpatient Behavioral Health20% after deductible\$0Outpatient Facility20% after deductible\$0Outpatient Facility20% after deductible\$0Outpatient Behavioral Health20% after deductible\$0Outpatient Behavioral HealthSee in-network deductible ¹¹ Deductible - IndividualSee in-network deductible ¹¹ \$0Deductible - IndividualSee in-network deductible ¹¹ \$0Deductible - FamilySee in-network deductible ¹¹ \$0Coinsurance After Deductible\$6,100\$0Out-of-Pocket Coinsurance Maximum - Individual\$6,100\$12,200	Specialist Office Visit	20% after deductible	\$30	
Physical/Occupational/Speech Therapy ⁴ 20% after deductible \$30 DIAGNOSTIC LABORATORY'/RADIOLOGY/ADVANCED IMAGING	Annual Routine Vision (In-Network Only)	20% after deductible	\$30	
DIAGNOSTIC LABORATORY'RADIOLOGY/ADVANCED IMAGING Outpatient Laboratory/Radiology/Advanced Imaging 20% after deductible \$0 Emergency/Radiology/Advanced Imaging 20% after deductible \$0 Urgent Care Center 20% after deductible \$45 Emergency Room 20% after deductible \$100 ^a Ambulance 20% after deductible \$0 OTHER SERVICES 1 Inpatient Facility 20% after deductible \$0 Outpatient Facility 50 Outpatient Facilit	Chiropractic ⁵	20% after deductible	\$30	
Outpatient Laboratory/Radiology/Advanced Imaging 20% after deductible \$0 Freestanding Laboratory/Radiology/Advanced Imaging 20% after deductible \$0 EMERGENCY/URGENT MEDICAL SERVICES V V Urgent Care Center 20% after deductible \$45 Emergency Room 20% after deductible \$0 0 Ambulance 20% after deductible \$0 0 OTHER SERVICES V V V Inpatient Facility 20% after deductible \$0 0 Outpatient Behavioral Health 20% after deductible \$0 0 Outpatient Facility 20% after deductible \$30 0 Outpatient Behavioral Health 20% after deductible \$30 V Outpotient Facility 20% after deductible \$100 deductible, then covered in full OUTFOF-NETWORK (OON)* V V No out-of-network dence Deductible - Individual See in-network deductible* ¹¹ No out-of-network benefits Coinsurance Maximum - Individual \$6,100 No out-of-network benefits Out-of-Pocket Coinsurance Ma	Physical/Occupational/Speech Therapy ⁶	20% after deductible	\$30	
Freestanding Laboratory/Radiology/Advanced Imaging 20% after deductible \$0 EMERGENCY/URGENT MEDICAL SERVICES 20% after deductible \$45 Urgent Care Center 20% after deductible \$00° Emergency Room 20% after deductible \$0 Ambulance 20% after deductible \$0 OTHER SERVICES Inpatient Facility 20% after deductible \$0 Outpatient Facility 20% after deductible \$0 Outpatient Behavioral Health 20% after deductible \$0 Outpatient Behavioral Health 20% after deductible \$100 deductible, then covered in full Outpatient Behavioral Health 20% after deductible \$100 deductible, then covered in full Outpot-FNETWORK (OON)** V Y Y Deductible - Individual See in-network deductible** No out-of-network benefits Deductible - Family See in-network deductible** No out-of-network benefits Coinsurance after Deductible \$(100 No out-of-network benefits Out-of-Pocket Coinsurance Maximum - Individual \$(2,200 No out-of-network benefits	DIAGNOSTIC LABORATORY7/RADIOLOGY/ADVANCED IMAGING			
EMERGENCY/URGENT MEDICAL SERVICES 20% after deductible \$45 Urgent Care Center 20% after deductible \$100° Emergency Room 20% after deductible \$0 Ambulance 20% after deductible \$0 OTHER SERVICES Impatient Facility 20% after deductible \$0 Outpatient Facility 20% after deductible \$0 Impatient Outpatient Behavioral Health 20% after deductible \$0 Impatient Outpatient Behavioral Health 20% after deductible \$0 Impatient Outpatient Behavioral Health 20% after deductible \$0 Impatient Durable Medical Equipment (DME) 20% after deductible \$30 Impatient OUT-OF-NETWORK (OON)** Impatient See in-network deductible*** \$30 Impatient facility Deductible - Individual See in-network deductible*** \$100 deductible, then covered in full Out-of-Pocket Coinsurance Maximum - Individual \$6,100 No out-of-network benefits Out-of-Pocket Coinsurance Maximum - Family \$12,200 No out-of-network benefits	Outpatient Laboratory/Radiology/Advanced Imaging	20% after deductible	\$0	
Urgent Care Center 20% after deductible \$45 Emergency Room 20% after deductible \$100 ^s Ambulance 20% after deductible \$0 OTHER SERVICES Impatient Facility 20% after deductible \$0 Outpatient Facility 20% after deductible \$0 Impatient Facility Outpatient Behavioral Health 20% after deductible \$0 Impatient Facility Outpatient Behavioral Health 20% after deductible \$30 Impatient Geductible, then covered in full Outpatient Behavioral Health 20% after deductible \$100 deductible, then covered in full Durable Medical Equipment (DME) 20% after deductible \$100 deductible, then covered in full OUT-OF-NETWORK (OON) ¹⁰ Impatient See in-network deductible ¹¹ \$100 deductible, then covered in full Deductible - Family See in-network deductible ¹¹ No out-of-network benefits Coinsurance after Deductible \$6,100 No out-of-network benefits Out-of-Pocket Coinsurance Maximum - Family \$12,200 No out-of-network benefits	Freestanding Laboratory/Radiology/Advanced Imaging	20% after deductible	\$0	
Emergency Room 20% after deductible \$100 ^a Ambulance 20% after deductible \$0 OTHER SERVICES 20% after deductible \$0 Outpatient Facility 20% after deductible \$0 Outpatient Facility 20% after deductible \$0 Outpatient Behavioral Health 20% after deductible \$30 Outpatient Behavioral \$40% After Genavioration \$40% Afte	EMERGENCY/URGENT MEDICAL SERVICES			
Ambulance20% after deductible\$0OTHER SERVICES20% after deductible\$0Inpatient Facility20% after deductible\$0Outpatient Facility20% after deductible\$0Outpatient Facility20% after deductible\$0Outpatient Behavioral Health20% after deductible\$30Durable Medical Equipment (DME)20% after deductible\$100 deductible, then covered in fullOUTOF-NETWORK (OON) ¹⁰ 100100Deductible - IndividualSee in-network deductible ¹¹ Deductible - FamilySee in-network deductible ¹¹ Coinsurance after Deductible\$6,100No out-of-network benefitsOut-of-Pocket Coinsurance Maximum - Individual\$12,200*********************************	Urgent Care Center	20% after deductible	\$45	
OTHER SERVICESImpatient Facility20% after deductibleSoleOutpatient Facility20% after deductible\$0Outpatient Facility20% after deductible\$0Outpatient Behavioral Health20% after deductible\$30Durable Medical Equipment (DME)20% after deductible\$100 deductible, then covered in fullOUT-OF-NETWORK (OON) ¹⁰ 20% after deductible\$100 deductible, then covered in fullDeductible - IndividualSee in-network deductible ¹¹ Peductible - FamilyDeductible - FamilySee in-network deductible ¹¹ No out-of-network benefitsOut-of-Pocket Coinsurance Maximum - Individual\$12,200No out-of-network benefits	Emergency Room	20% after deductible	\$100 ⁸	
Inpatient Facility20% after deductible\$0Outpatient Facility20% after deductible\$0Outpatient Behavioral Health20% after deductible\$30Durable Medical Equipment (DME)20% after deductible\$100 deductible, then covered in fullOUTOF-NETWORK (OON)*0VVDeductible - IndividualSee in-network deductible ¹¹ Heat the see in-network deductible ¹¹ Deductible - FamilySee in-network deductible ¹¹ Heat the see in-network benefitsOut-of-Pocket Coinsurance Maximum - Individual\$6,100Heat the see in-network benefitsOut-of-Pocket Coinsurance Maximum - Family\$12,200Heat the see in-network benefits	Ambulance	20% after deductible	\$0	
Inpatient Facility20% after deductible\$0Outpatient Facility20% after deductible\$0Outpatient Behavioral Health20% after deductible\$30Durable Medical Equipment (DME)20% after deductible\$100 deductible, then covered in fullOUTOF-NETWORK (OON)*0VVDeductible - IndividualSee in-network deductible ¹¹ Heat the see in-network deductible ¹¹ Deductible - FamilySee in-network deductible ¹¹ Heat the see in-network benefitsOut-of-Pocket Coinsurance Maximum - Individual\$6,100Heat the see in-network benefitsOut-of-Pocket Coinsurance Maximum - Family\$12,200Heat the see in-network benefits	OTHER SERVICES			
Outpatient Behavioral Health 20% after deductible \$30 Durable Medical Equipment (DME) 20% after deductible \$100 deductible, then covered in full OUT-OF-NETWORK (OON) ¹⁰ Image: Comparison of the term of t	Inpatient Facility	20% after deductible	\$0	
Durable Medical Equipment (DME) 20% after deductible \$100 deductible, then covered in full OUT-OF-NETWORK (OON) ¹⁰ Image: Comparison of the term of ter	Outpatient Facility	20% after deductible	\$0	
OUT-OF-NETWORK (OON) ¹⁰ See in-network deductible ¹¹ Deductible - Individual See in-network deductible ¹¹ Deductible - Family See in-network deductible ¹¹ Coinsurance after Deductible 40% Out-of-Pocket Coinsurance Maximum - Individual \$6,100 Out-of-Pocket Coinsurance Maximum - Family \$12,200	Outpatient Behavioral Health	20% after deductible	\$30	
Deductible - Individual See in-network deductible ¹¹ Deductible - Family See in-network deductible ¹¹ Coinsurance after Deductible 40% Out-of-Pocket Coinsurance Maximum - Individual \$6,100 Out-of-Pocket Coinsurance Maximum - Family \$12,200	Durable Medical Equipment (DME)	20% after deductible	\$100 deductible, then covered in full	
Deductible - FamilySee in-network deductible11Coinsurance after Deductible40%Out-of-Pocket Coinsurance Maximum - Individual\$6,100Out-of-Pocket Coinsurance Maximum - Family\$12,200	OUT-OF-NETWORK (OON) ¹⁰			
Coinsurance after Deductible 40% No out-of-network benefits Out-of-Pocket Coinsurance Maximum - Individual \$6,100 No out-of-network benefits Out-of-Pocket Coinsurance Maximum - Family \$12,200 \$12,200	Deductible - Individual	See in-network deductible ¹¹		
Out-of-Pocket Coinsurance Maximum - Individual\$6,100No out-of-network benefitsOut-of-Pocket Coinsurance Maximum - Family\$12,200	Deductible - Family	See in-network deductible ¹¹		
Out-of-Pocket Coinsurance Maximum - Individual \$6,100 Out-of-Pocket Coinsurance Maximum - Family \$12,200	Coinsurance after Deductible	40%	No out of network bonefite	
	Out-of-Pocket Coinsurance Maximum - Individual	\$6,100	NO OUT-OF-HELWORK DENETITS	
Inpatient Hospital Deductible Not applicable	Out-of-Pocket Coinsurance Maximum - Family	\$12,200		
	Inpatient Hospital Deductible	Not applicable		

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HorizonBlue.com/shbp 1-800-414-SHBP (7427)	OMNIA Tiere	OMNIA Tiered Network Plan		PPO Plans	
	OMNIA HEALTH PLAN		NJ DIRECT (employees hired prior to 7/1/19)	NJ DIRECT2019 (new hires on or after 7/1/19	
	Tier 1	Tier 2			
IN-NETWORK (IN)					
Service Area Available	NJ only	Nationwide	Nationwide	Nationwide	
Specialist Referral	No referral required	No referral required	No referral required	No referral required	
Deductible ²					
Individual	\$0	\$1,500	\$0	\$100	
Family	\$0	\$3,000	\$0	Not applicable	
Coinsurance	0%	20% after deductible	10%4	10% after deductible⁴	
Coinsurance Out-of-Pocket Maximum					
Individual	Not applicable	Not applicable	\$800	\$800	
Family	Not applicable	Not applicable	\$2,000	\$2,000	
Total Out-of-Pocket Maximum (Copay+Deductible+Coinsura	nce)				
Individual	\$2,500	\$4,500	\$7,560	\$7,560	
Family	\$5,000	\$9,000	\$15,120	\$15,120	
HEALTH CARE SERVICES					
Primary Care Office Visit	\$5	\$20	\$15	\$15	
Annual Routine Physical (In-Network Only)	\$0	\$0	\$0	\$0	
Direct Primary Care (DPC) Doctors Office	\$0	\$0	\$0	\$0	
First Responders Doctors Office (FRDOCS)	\$0	\$0	\$0	\$0	
Horizon CareOnline (Telemedicine)	Cost share may apply	Cost share may apply	Cost share may apply	Cost share may apply	
Specialist Office Visit	\$20	\$35	\$30	\$30	
Annual Routine Vision (In-Network Only)	\$20	\$35	\$30	\$30	
Chiropractic ⁶	\$20	\$35	\$30	\$30	
Physical/Occupational/Speech Therapy ⁷	\$20 office visit/ \$20 outpatient facility	\$35 office visit/ 20% after deductible at an outpatient facility	\$30	\$30	
DIAGNOSTIC LABORATORY [®] /RADIOLOGY/ADVANCED II	MAGING				
Outpatient Laboratory/Radiology/Advanced Imaging	\$20	20% after deductible	\$0	\$0	
Freestanding Laboratory/Radiology/Advanced Imaging	\$0	\$0	\$0	\$0	
EMERGENCY/URGENT MEDICAL SERVICES					
Urgent Care Center	\$35	\$50	\$45	\$45	
Emergency Room	\$100	\$100	\$150°	\$150°	
Ambulance	\$0	\$0	10%	10% after deductible	
OTHER SERVICES					
Inpatient Facility	\$150 per admission ¹⁰	20% after deductible	\$0	\$0	
Outpatient Facility	\$150	20% after deductible	\$0	\$0	
Outpatient Behavioral Health	\$20	\$35 office visit/ 20% after deductible at an outpatient facility	\$30	\$30	
Durable Medical Equipment (DME)	\$0	\$0	10%	10% after deductible	
OUT-OF-NETWORK (OON)11					
Deductible - Individual			\$400	\$400	
Deductible - Family	No out-of-network benefits		\$1,000	\$1,000	
Coinsurance after Deductible			30%	30%	
Out-of-Pocket Coinsurance Maximum - Individual			\$2,000	\$2,000	
Out-of-Pocket Coinsurance Maximum - Mainteual			\$5,000	\$5,000	
Inpatient Hospital Deductible			\$500/stay	\$500/stay	

1. High Deductible Health Plan. NJ DIRECT HDLow plan includes \$300 Health Savings Account funding by employer.

2. Deductible applies to all services that require a coinsurance.

3. Includes eligible prescription cost share.

4. On select services (durable medical equipment, prosthetics, orthotics, oxygen, private duty nursing, ambulance).

4. Un select services (durable medical equipment, prostnetics, ornotics, oxygen, private duty hursing, ambulance).
5. Under age 26.
6. Chiropractic: Horizon HMO: 20 visits per calendar year. OMNIA Health Plan: 25 visits per calendar year. All other plans: 30 visits per calendar year.
7. Physical, occupational and speech therapy: OMNIA Health Plan: 30 visit maximum each per calendar year. Horizon HMO: 60 visit combined maximum per calendar year. All other plans based on medical necessity.
8. Laboratory services must be rendered by an in-network participating provider, with some exceptions based on medical policy.
9. Lower copayment applies to children under 19 and physician referrals.

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HorizonBlue.com/shbp 1-800-414-SHBP (7427)	PPO Plans			
	NJ DIRECT15	NJ DIRECT1525	NJ DIRECT2030	
IN-NETWORK (IN) Service Area Available	Nationwide	Nationwide	Nationwide	
Specialist Referral Deductible ¹	No referral required	No referral required	No referral required	
	¢o	\$0	\$0	
Individual	\$0 \$0			
Family	\$0 10%/4	\$0	\$0 1 02/ 4	
	10%4	10%4	10%4	
Coinsurance Out-of-Pocket Maximum	¢	¢ 100	¢000	
Individual	\$400	\$400	\$800	
Family	\$1,000	\$1,000	\$2,000	
Total Out-of-Pocket Maximum (Copay+Deductible+Coinsura				
Individual	\$7,560	\$7,560	\$7,560	
Family	\$15,120	\$15,120	\$15,120	
HEALTH CARE SERVICES				
Primary Care Office Visit	\$15	\$15	\$20	
Annual Routine Physical (In-Network Only)	\$0	\$0	\$0	
Direct Primary Care (DPC) Doctors Office	\$0	\$0	\$0	
First Responders Doctors Office (FRDOCS)	\$0	\$0	\$0	
Horizon CareOnline (Telemedicine)	Cost share may apply	Cost share may apply	Cost share may apply	
Specialist Office Visit	\$15	\$25	\$30/adult, \$20/child⁵	
Annual Routine Vision (In-Network Only)	\$15	\$25	\$30/adult, \$20/child⁵	
Chiropractic⁵	\$15	\$25	\$30/adult, \$20/child⁵	
Physical/Occupational/Speech Therapy ⁷	\$15	\$25	\$30/adult, \$20/child⁵	
DIAGNOSTIC LABORATORY ⁸ /RADIOLOGY/ADVANCED	MAGING			
Outpatient Laboratory/Radiology/Advanced Imaging	\$0	\$0	\$0	
Freestanding Laboratory/Radiology/Advanced Imaging	\$0	\$0	\$0	
EMERGENCY/URGENT MEDICAL SERVICES				
Urgent Care Center	\$15	\$25	\$30/adult, \$20/child⁵	
Emergency Room	\$100 ⁹	\$100°	\$125	
Ambulance	10%	10%	10%	
OTHER SERVICES				
Inpatient Facility	\$0	\$0	\$0	
Outpatient Facility	\$0	\$0	\$0	
Outpatient Behavioral Health	\$15	\$25	\$30/adult, \$20/child⁵	
Durable Medical Equipment (DME)	10%	10%	10%	
OUT-OF-NETWORK (OON)11				
Deductible - Individual	\$100	\$100	\$200	
Deductible - Family	\$250	\$250	\$500	
Coinsurance after Deductible	30%	30%	30%	
Out-of-Pocket Coinsurance Maximum - Individual	\$2,000	\$2,000	\$5,000	
Out-of-Pocket Coinsurance Maximum - Family	\$5,000	\$5,000	\$12,500	
Inpatient Hospital Deductible	\$200/stay	\$200/stay	\$500/stay	

10. \$150 per admission does not apply to inpatient childbirth, hospice or inpatient behavioral health/substance use disorder.

11. Out-of-network cost basis: NJ DIRECT and NJ DIRECT2019: 175% of CMS (Centers for Medicare & Medicaid Services) fee schedule. 90th percentile of FAIR Health national for all other health plans with an out-of-network benefit. All plans with an out-of-network benefit also have specified dollar limits for out-of-network chiropractic (\$35), physical therapy (\$52) and acupuncture (\$60).

12. Out-of-network deductible is combined with in-network deductible.

This is not a complete list of all covered services. Exclusions and limitations apply to some services. Visit <u>nj.gov/treasury/pensions/member-guidebooks.shtml</u> for more information. Horizon Dental Choice plan available. Please visit <u>HorizonBlue.com/shbp</u>.

Retirees: Please visit **nj.gov/treasury/pensions** for information regarding available retiree plans. This document is for informational purposes only and does not constitute a binding agreement. The information provided by this document is not intended to replace or modify the terms, conditions, limitations and exclusions contained within health plans issued or administered by Horizon. In the event of a conflict between the information contained in this document and your plan documents, your plan documents shall control.

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HorizonBlue.com/shbp 1-800-414-SHBP (7427)	PPO Plan High Deductik		ible PPO Plans	HMO Plan	
	NJ DIRECT2035	NJ DIRECT HDLow ¹	NJ DIRECT HDHigh	HORIZON HMO	
IN-NETWORK (IN)					
Service Area Available	Nationwide	Nationwide	Nationwide	NJ and contiguous counti	
Specialist Referral	No referral required	No referral required	No referral required	Referral required	
	No reienai required	No referrar required	No referrar required	Referrar required	
Individual	\$200	\$1,600 ³	\$4,100 ³	See DME	
	\$500			See DME	
Family	20% after deductible	\$3,200 ³ 20% after deductible ³	\$8,200 ³		
	20% after deductible	20% after deductible*	20% after deductible ³	0%	
Coinsurance Out-of-Pocket Maximum	¢2,000	¢1 000	¢1.000	Net en l'estele	
	\$2,000	\$1,000	\$1,000	Not applicable	
	\$5,000	\$2,000	\$2,000	Not applicable	
Total Out-of-Pocket Maximum (Copay+Deductible+Coinsura		¢0 (003	¢5 4003	¢7 5/0	
	\$7,560	\$2,600 ³	\$5,100 ³	\$7,560	
	\$15,120	\$5,200 ³	\$10,200 ³	\$15,120	
HEALTH CARE SERVICES					
Primary Care Office Visit	\$20	20% after deductible	20% after deductible	\$15	
Annual Routine Physical (In-Network Only)	\$0	\$0	\$0	\$0	
Direct Primary Care (DPC) Doctors Office	\$0	Not available	Not available	Not available	
First Responders Doctors Office (FRDOCS	\$0	\$0	\$0	\$0	
Horizon CareOnline (Telemedicine)	Cost share may apply	Cost share may apply	Cost share may apply	Cost share may apply	
Specialist Office Visit	\$35	20% after deductible	20% after deductible	\$30	
Annual Routine Vision (In-Network Only)	\$35	20% after deductible	20% after deductible	\$30	
Chiropractic ⁵	\$35	20% after deductible	20% after deductible	\$30	
Physical/Occupational/Speech Therapy ⁷	\$35 office visit/ 20% after deductible at an outpatient facility	20% after deductible	20% after deductible	\$30	
DIAGNOSTIC LABORATORY8/RADIOLOGY/ADVANCED II	MAGING				
Outpatient Laboratory/Radiology/Advanced Imaging	20% after deductible	20% after deductible	20% after deductible	\$0	
Freestanding Laboratory/Radiology/Advanced Imaging	20% after deductible	20% after deductible	20% after deductible	\$0	
EMERGENCY/URGENT MEDICAL SERVICES					
Urgent Care Center	\$35	20% after deductible	20% after deductible	\$45	
Emergency Room	\$300	20% after deductible	20% after deductible	\$100 ⁹	
Ambulance	20% after deductible	20% after deductible	20% after deductible	\$0	
OTHER SERVICES					
Inpatient Facility	20% after deductible	20% after deductible	20% after deductible	\$0	
Outpatient Facility	20% after deductible	20% after deductible	20% after deductible	\$0	
Outpatient Behavioral Health	\$35 office visit/ 20% after deductible at an outpatient facility	20% after deductible	20% after deductible	\$30	
Durable Medical Equipment (DME)	20% after deductible	20% after deductible	20% after deductible	\$100 deductible, then covered in full	
Deductible - Individual	\$800	See in-network deductible ¹²	See in-network deductible ¹²		
Deductible - Family	\$2,000	See in-network deductible ¹²	See in-network deductible ¹²	No out-of-network	
Coinsurance after Deductible	40%	40%	40%		
Out-of-Pocket Coinsurance Maximum - Individual	\$6,500	\$3,600	\$6,100	benefits	
Out-of-Pocket Coinsurance Maximum - Family	\$13,000	\$7,200	\$12,200		
Inpatient Hospital Deductible	\$600/stay	Not applicable	Not applicable		

With Horizon health plans, we've got you covered.

Well Care and Preventive Care

Services such as an annual physical and gynecological exam, well baby/child medical care, immunizations and an annual vision exam are covered when using a participating doctor.

Behavioral Health and Substance Use Disorder

We empower our members to achieve their best physical and mental health. Our care team will work with you, your family, caregivers and doctors to make sure you are getting the treatment and support you need in the most appropriate setting. Telehealth and virtual programs are available.

NEW- Horizon MindCareSM

This secure online behavioral health platform offers personalized behavioral health and resilience information, well-being assessments, tools and resources. Plus, it can match you to reliable in-network providers, facilities and virtual health solutions.

In-Network Laboratories

Our members have access to in-network lab services. You can use Quest Diagnostics™ (Quest) or LabCorp for blood tests and other lab services. Our networks also include a number of other participating labs that provide specialized lab services.

Prescription Drug Coverage

Prescription drug coverage is available to all SHBP and SEHBP members. To learn more, refer to the Prescription Drug Plan information on the NJ Division of Pensions and Benefits website at <u>nj.gov/treasury/pensions</u>.

24/7 Nurse Line

For everyday health questions, or even a situation that might be more serious, access trusted information by calling the 24/7 Nurse Line at 1-888-624-3096.

Learn more at HorizonBlue.com/shbp





Making good health care more convenient.

Direct Primary Care (DPC)

Eligible members get unlimited access to personalized care with no copays. Simply choose a DPC doctor from Everside Health or Sanitas Medical Center for you and your covered dependents.

If you are eligible for NJWELL, your DPC provider will credit a well visit and follow-up office visit as a completed health screening.

First Responders Program

If you are an eligible first responder, you and your covered family members can receive care at a First Responders Doctors Office (FRDOCS) with no cost share.

Retail Health Clinics

These clinics treat common health issues such as colds or seasonal allergies.

- On-site board-certified nurse practitioners can diagnose and treat conditions and prescribe medications.
- Sites include MinuteClinics® at select CVS/ pharmacy® locations.

Telemedicine

Telemedicine is available at the touch of a button through the Horizon Blue app for eligible members. And depending on your doctor's preferences, you can also use telemedicine via video, chat or phone.

Immunizations

Getting vaccinated is more convenient with more participating pharmacies – view our list at HorizonBlue.com/shbpflu.

- Vaccines these pharmacies administer include flu, COVID-19, shingles, hepatitis A and B, pneumococcal and human papillomavirus (HPV).
- Medical claims are automatically submitted for you.

Urgent Care Centers

Urgent care centers provide immediate medical care as an alternative to visiting the Emergency Room (ER). They treat wounds, sprains and other conditions that need immediate attention, but are not life-threatening.

- HMO members require a referral to go to a Horizon urgent care center.
- All members are responsible for applicable copayments/coinsurance.
- Routine office visits are not covered at urgent care centers.

Learn more at HorizonBlue.com/shbp

Connect to care, benefits and support anytime.

With the Horizon Blue app, you can:

- Get help with appointment scheduling
- Get quick claim status updates
- Video chat with doctors
- View and print member ID Cards
- Locate in-network doctors

Need help registering for our Horizon Blue app or our secure member website? Call the eService Help Desk at **1-888-777-5075** weekdays from 7 a.m. to 6 p.m., ET.



Google play

Text GetApp to **422-272** for your free Horizon Blue download.*

*There is no charge to download the Horizon Blue app, but rates from your wireless provider may apply.

Here when you need us most.

Visit us online at <u>HorizonBlue.com/shbp</u>. Chat with us online. Contact us toll free at **1-800-414-SHBP (7427)**.



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Quest Diagnostics[™] and LabCorp are independent companies that provide lab services to eligible SHBP and SEHBP members.

Everside Health and Sanitas Medical Center are independent companies that support Horizon in providing comprehensive primary care, urgent care and preventive care services to eligible SHBP and SEHBP members. YMCA is independent company that supports Horizon in the administration of a membership discount program.

Walgreens is an independent company that supports Horizon in providing health information and preventative screenings.

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Spanish (Español): Para ayuda en español, Ilame al 1-866-660-6528 (TTY 711). Chinese (中文): 如需中文協助, 請致電 1-866-660-6528 (TTY 711).