# 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<sup>s</sup>™

Eligible SHBP members may receive a \$20 reward<sup>1</sup> 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<sup>®</sup>, get weekly email deals from top retailers, including gym memberships, nutrition programs, glasses, contacts and more.

# YMCA Discount<sup>2</sup>

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 Discount<sup>2</sup>

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 <sup>2</sup>			
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 <sup>6</sup>	\$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 <sup>9</sup>	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) <sup>10</sup>			
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.

 <sup>4.</sup> 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 <sup>1</sup>	
IN-NETWORK (IN)				
Service Area Available	Nationwide	Nationwide	Nationwide	
Specialist Referral	No referral required	No referral required	No referral required	
Deductible <sup>2</sup>				
Individual	\$0	\$100	\$1,600 <sup>3</sup>	
Family	\$0	Not applicable	\$3,200 <sup>3</sup>	
Coinsurance	10%4	10% after deductible <sup>4</sup>	20% after deductible <sup>3</sup>	
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 <sup>3</sup>	
Family	\$15,120	\$15,120	\$5,200 <sup>3</sup>	
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 <sup>5</sup>	\$30	\$30	20% after deductible	
Physical/Occupational/Speech Therapy <sup>6</sup>	\$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 <sup>8</sup>	\$150 <sup>8</sup>	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) <sup>10</sup>				
Deductible - Individual	\$400	\$400	See in-network deductible <sup>11</sup>	
Deductible - Family	\$1,000	\$1,000	See in-network deductible <sup>11</sup>	
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)

Annual Routine Physical (in-Network Only)S0S0Direct Primary Care (DPC) Doctors Office (FRDOCS)Not availableNot availableFirst Responders Doctors Office (FRDOCS)S0S0Horizon CareOnline (Telemedicine)Cost share may applyCost share may applySpecialist Office VisitOxet share may applyS0Annual Routine Vision (In-Network Only)20% after deductibleS30Chiropractic <sup>3</sup> 20% after deductibleS30Physical/Occupational/Speech Theraps <sup>4</sup> 20% after deductibleS0OLAGNOSTIC LABORATORY/RADIOLOGY/ADVANCED IMACINCUUrtpatient Laboratory/Radiology/Advanced Imaging20% after deductibleS0Prestanding Laboratory/Radiology/Advanced Imaging20% after deductibleS0Chroger Care Center20% after deductibleS0Benegency Room20% after deductibleS0Outpatient Facility20% after deductibleS0Outpatient Bachirola Health20% after deductibleS0Outpatient Bachirola Health20% after deductibleS0Outpatient Facility20% after deductibleS0Outpatient Facility20% after deductibleS0Outpatient Facility20% after deductibleS0Outpatient FacilityS0S0Outpatient Facil	HorizonBlue.com/shbp 1-800-414-SHBP (7427)	High Deductible PPO Plan	HMO Plan	
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Family     \$10,200 <sup>3</sup> \$15,120       HEALT CARE SERVICES     I       Primary Care Office Viait     20% after deductible     \$15       Annual Routine Physical (In-Network Only)     50     50       Direct Primary Care (DPC) Doctors Office     Not available     Not available       First Responders Doctors Office (FRDOCS)     50     50       Annual Routine Vision (In-Network Only)     Cost share may apply     Cost share may apply       Specialist Office Visit     20% after deductible     530       Annual Routine Vision (In-Network Only)     20% after deductible     530       Chiropractic <sup>4</sup> 20% after deductible     530       Physical/Occupational/Speech Therapy     20% after deductible     50       Outpatient Laboratory/Radiology/Advanced Imaging     20% after deductible     50       Outpatient Laboratory/Radiology/Advanced Imaging     20% after deductible     50       Emergency Room     20% after deductible     50       Ambulance     20% after deductible     50       Coltpatient Laboratory/Radiology/Advanced Imaging     20% after deductible     50       Emergency Room     20% after deductible     50       Ambulance     20% after deductible     50       Outpatient Facility     20% after deductible     50       Outpatient Facility     20% after de				
HEALTH CARE SERVICES         UN           Primary Care Office Visit         20% after deductible         515           Annual Routine Physical (in-Network Only)         50         50           Direct Primary Care (DFC) Doctors Office         Not available         Not available           First Responders Doctors Office (FRDOCS)         50         50           Specialits Office Visit         20% after deductible         530           Annual Routine Vision (In-Network Only)         20% after deductible         530           Specialits Office Visit         20% after deductible         530           Annual Routine Vision (In-Network Only)         20% after deductible         530           Physical/Occupational/Speech Therapy*         20% after deductible         530           DIAGNOSTIC LABORATORY/RADIOLOGY/ADVANCED IMAGING         Uncupational Radiology/Advanced Imaging         20% after deductible           DiAGNOSTIC LABORATORY/RADIOLOGY/ADVANCED IMAGING         Uncupational Laboratory/Radiology/Advanced Imaging         20% after deductible         50           DiAGNOSTIC LABORATORY/RADIOLOGY/ADVANCED IMAGING         Uncupation Laboratory/Radiology/Advanced Imaging         20% after deductible         50           Direget Care Center         20% after deductible         50         50           Direget Care Center         20% after deductible         5	Individual			
Primary Care Office Visit20% after deductible\$15Annual Routine Physical (In-Network Only)5050Direct Primary Care (DPC) Doctos OfficeNot availableNot availableFirst Responders Doctors Office (FRDOCS)5050Horizon Care Online (Telemedicine)Cost share may applyCost share may applySpecialist Office Visit20% after deductible\$30Annual Routine Vision (In-Network Only)20% after deductible\$30Ohrspratic <sup>5</sup> 20% after deductible\$30Physical/Occupational/Speech Therapy <sup>4</sup> 20% after deductible\$30Outpatient Laboratory/Radiology/Advanced Imaging20% after deductible\$0Outpatient Laboratory/Radiology/Advanced Imaging20% after deductible\$10Emergency Room20% after deductible\$10Chrogenster20% after deductible\$10Emergency Room20% after deductible\$10Annual Routine Physical/Occupational/Speech Therapy <sup>4</sup> 20% after deductible\$10Freestanding Laboratory/Radiology/Advanced Imaging20% after deductible\$10Bergency Room20% after deductible\$100 aAnnual Routine Physical/Concerter20% after deductible\$10Inpatient Facility20% after deductible\$10Outpatient Facili	-	\$10,200 <sup>3</sup>	\$15,120	
Annual Routine Physical (in-Network Only)S0S0Direct Primary Care (DPC) Doctors Office (FRDOCS)Not availableNot availableFirst Responders Doctors Office (FRDOCS)S0S0Horizon CareOnline (Telemedicine)Cost share may applyCost share may applySpecialist Office VisitOxet share may applyS0Annual Routine Vision (In-Network Only)20% after deductibleS30Chiropractic <sup>3</sup> 20% after deductibleS30Physical/Occupational/Speech Theraps <sup>4</sup> 20% after deductibleS0OLAGNOSTIC LABORATORY/RADIOLOGY/ADVANCED IMACINCUUrtpatient Laboratory/Radiology/Advanced Imaging20% after deductibleS0Prestanding Laboratory/Radiology/Advanced Imaging20% after deductibleS0Chroger Care Center20% after deductibleS0Benegency Room20% after deductibleS0Outpatient Facility20% after deductibleS0Outpatient Bachirola Health20% after deductibleS0Outpatient Bachirola Health20% after deductibleS0Outpatient Facility20% after deductibleS0Outpatient Facility20% after deductibleS0Outpatient Facility20% after deductibleS0Outpatient FacilityS0S0Outpatient Facil	HEALTH CARE SERVICES			
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 <sup>3</sup> 20% after deductible         \$30           Physical/Occupational/Speech Therapy <sup>4</sup> 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 <sup>4</sup> Concenter         20% after deductible         \$100 <sup>4</sup> 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 <sup>a</sup> Anbulance     20% after deductible     \$100 <sup>a</sup> 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 <sup>2</sup> 20% after deductible         530           Physical/Occupational/Speech Therapy <sup>4</sup> 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 <sup>4</sup> 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 <sup>11</sup> Deductible - IndividualSee in-network deductible <sup>11</sup> \$0Deductible - IndividualSee in-network deductible <sup>11</sup> \$0Deductible - FamilySee in-network deductible <sup>11</sup> \$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 <sup>4</sup> 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 <sup>a</sup> Ambulance 20% after deductible \$0 OTHER SERVICES 1 Inpatient Facility 20% after deductible \$0 Outpatient Facility 50 Outpatient Facilit	Chiropractic <sup>5</sup>	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* <sup>11</sup> No out-of-network benefits           Coinsurance Maximum - Individual         \$6,100         No out-of-network benefits           Out-of-Pocket Coinsurance Ma	Physical/Occupational/Speech Therapy <sup>6</sup>	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 <sup>s</sup> 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) <sup>10</sup> Impatient See in-network deductible <sup>11</sup> \$100 deductible, then covered in full         Deductible - Family       See in-network deductible <sup>11</sup> 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 <sup>a</sup> 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) <sup>10</sup> 100100Deductible - IndividualSee in-network deductible <sup>11</sup> Deductible - FamilySee in-network deductible <sup>11</sup> 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) <sup>10</sup> 20% after deductible\$100 deductible, then covered in fullDeductible - IndividualSee in-network deductible <sup>11</sup> Peductible - FamilyDeductible - FamilySee in-network deductible <sup>11</sup> No out-of-network benefitsOut-of-Pocket Coinsurance Maximum - Individual\$12,200No out-of-network benefits	Emergency Room	20% after deductible	\$100 <sup>8</sup>	
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 <sup>11</sup> Heat the see in-network deductible <sup>11</sup> Deductible - FamilySee in-network deductible <sup>11</sup> 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 <sup>11</sup> Heat the see in-network deductible <sup>11</sup> Deductible - FamilySee in-network deductible <sup>11</sup> 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) <sup>10</sup> 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) <sup>10</sup> Image: Comparison of the term of ter	Outpatient Facility	20% after deductible	\$0	
OUT-OF-NETWORK (OON) <sup>10</sup> See in-network deductible <sup>11</sup> Deductible - Individual       See in-network deductible <sup>11</sup> Deductible - Family       See in-network deductible <sup>11</sup> 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 <sup>11</sup> Deductible - Family     See in-network deductible <sup>11</sup> 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) <sup>10</sup>			
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 <sup>11</sup>		
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 <sup>11</sup>		
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		

# 2024 NJ SHBP State and State College/University Employees

#### **Plans for All Other State Members**

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



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 <sup>2</sup>					
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 <sup>6</sup>	\$20	\$35	\$30	\$30	
Physical/Occupational/Speech Therapy <sup>7</sup>	\$20 office visit/ \$20 outpatient facility	\$35 office visit/ 20% after deductible at an outpatient facility	\$30	\$30	
DIAGNOSTIC LABORATORY <sup>®</sup> /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 <sup>10</sup>	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.

# 2024 NJ SHBP State and State College/University Employees

#### **Plans for All Other State Members**

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



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 <sup>1</sup>	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 <sup>7</sup>	\$15	\$25	\$30/adult, \$20/child⁵	
DIAGNOSTIC LABORATORY <sup>8</sup> /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 <sup>9</sup>	\$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.

# 2024 NJ SHBP State and State College/University Employees

### Plans for All Other State Members

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



HorizonBlue.com/shbp 1-800-414-SHBP (7427)	PPO Plan High Deductik		ible PPO Plans	HMO Plan	
	NJ DIRECT2035	NJ DIRECT HDLow <sup>1</sup>	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 <sup>3</sup>	\$4,100 <sup>3</sup>	See DME	
	\$500			See DME	
Family	20% after deductible	\$3,200 <sup>3</sup> 20% after deductible <sup>3</sup>	\$8,200 <sup>3</sup>		
	20% after deductible	20% after deductible*	20% after deductible <sup>3</sup>	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 <sup>3</sup>	\$5,100 <sup>3</sup>	\$7,560	
	\$15,120	\$5,200 <sup>3</sup>	\$10,200 <sup>3</sup>	\$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 <sup>5</sup>	\$35	20% after deductible	20% after deductible	\$30	
Physical/Occupational/Speech Therapy <sup>7</sup>	\$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 <sup>9</sup>	
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 <sup>12</sup>	See in-network deductible <sup>12</sup>		
Deductible - Family	\$2,000	See in-network deductible <sup>12</sup>	See in-network deductible <sup>12</sup>	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 MindCare<sup>SM</sup>**

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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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.

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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).