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

Plans effective 1/1/2024 (effective 12/30/2023 for biweekly employees)

HorizonBlue.com/shbp 1-800-414-SHBP (7427)

| | OMNIA Tiered Network Option | |
|---|---|---|
| | 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 | $4,500 |
| Family | Not applicable | $9,000 |
| 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 |
| Chiropractic[5] | $20 | $35 |
| Physical/Occupational/Speech Therapy[6] | $20 office visit/$20 outpatient facility | $35 office visit/<br>20% after deductible at an outpatient facility |
| **DIAGNOSTIC LABORATORY[7]/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/<br>20% after deductible at an outpatient facility |
| Durable Medical Equipment (DME) | $0 | $0 |
| **OUT-OF-NETWORK (OON)[10]** | | |
| Deductible - Individual | No out-of-network benefits | |
| Deductible - Family | | |
| Coinsurance after Deductible | | |
| Out-of-Pocket Coinsurance Maximum - Individual | | |
| Out-of-Pocket Coinsurance Maximum - Family | | |
| Inpatient Hospital Deductible | | |

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).
5. Chiropractic: Horizon HMO: 20 visits per calendar year. OMNIA Health Plan: 25 visits per calendar year. All other plans: 30 visits per calendar year.
6. 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.
7. Laboratory services must be rendered by an in-network participating provider, with some exceptions based on medical policy.
8. Lower copayment applies to children under 19 and physician referrals.
9. $150 per admission does not apply to inpatient childbirth, hospice or inpatient behavioral health/substance use disorder.

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| | PPO Plan Options | | |
|---|---|---|---|
| | 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 | $0 |
| 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 LABORATORY[7]/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 |
| Inpatient Hospital Deductible | $500/stay | $500/stay | Not applicable |

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 **nj.gov/treasury/pensions/member-guidebooks.shtml** for more information.
You can reference **HorizonBlue.com/shbp** to determine your premium contribution.
Horizon Dental Choice plan available. Please visit **HorizonBlue.com/shbp**.
Retirees: Please visit **nj.gov/treasury/pensions** for information regarding available retiree plans.
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| | PPO Plan Options | HMO Option |
|---|---|---|
| | NJ DIRECT HDHigh | HORIZON HMO |
| **IN-NETWORK (IN)** | | |
| Service Area Available | Nationwide | NJ and contiguous counties |
| Specialist Referral | No referral required | Referral required |
| Deductible[2] | | |
| Individual | $4,100[3] | See DME |
| Family | $8,200[3] | See DME |
| Coinsurance | 20% after deductible[3] | 0% |
| Coinsurance Out-of-Pocket Maximum | | |
| Individual | $1,000 | Not applicable |
| Family | $2,000 | Not applicable |
| Total Out-of-Pocket Maximum (Copay+Deductible+Coinsurance) | | |
| Individual | $5,100[3] | $7,560 |
| Family | $10,200[3] | $15,120 |
| **HEALTH CARE SERVICES** | | |
| Primary Care Office Visit | 20% after deductible | $15 |
| Annual Routine Physical (In-Network Only) | $0 | $0 |
| Direct Primary Care (DPC) Doctors Office | Not available | Not available |
| 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[5] | 20% after deductible | $30 |
| Physical/Occupational/Speech Therapy[6] | 20% after deductible | $30 |
| **DIAGNOSTIC LABORATORY[7]/RADIOLOGY/ADVANCED IMAGING** | | |
| Outpatient Laboratory/Radiology/Advanced Imaging | 20% after deductible | $0 |
| Freestanding Laboratory/Radiology/Advanced Imaging | 20% after deductible | $0 |
| **EMERGENCY/URGENT MEDICAL SERVICES** | | |
| Urgent Care Center | 20% after deductible | $45 |
| Emergency Room | 20% after deductible | $100[8] |
| 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 | $30 |
| Durable Medical Equipment (DME) | 20% after deductible | $100 deductible, then covered in full |
| **OUT-OF-NETWORK (OON)[10]** | | |
| Deductible - Individual | See in-network deductible[11] | No out-of-network benefits |
| 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 | |
| Inpatient Hospital Deductible | Not applicable | |