

2025 NJ SHBP State and State College/University Employees

Plans for CWA and Union Negotiated Members

Plans effective 1/1/2025 (effective 12/28/2024 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
Chiropractic ⁵	\$20	\$35
Physical/Occupational/Speech Therapy ⁶	\$20 office visit/\$20 outpatient facility	\$35 office visit/ 20% after deductible at an outpatient facility
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	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 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	\$1,650 ³
Family	\$0	Not applicable	\$3,300 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 (Copoly+Deductible+Coinsurance)			
Individual	\$7,360	\$7,360	\$2,650 ³
Family	\$14,720	\$14,720	\$5,300 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 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	\$3,650
Out-of-Pocket Coinsurance Maximum - Family	\$5,000	\$5,000	\$7,300
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.

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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	High Deductible PPO Plan	HMO Plan
	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	\$4,150 ³	See DME
Family	\$8,300 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 (Copoly+Deductible+Coinsurance)		
Individual	\$5,150 ³	\$7,360
Family	\$10,300 ³	\$14,720
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 LABORATORY⁷/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	\$6,150	
Out-of-Pocket Coinsurance Maximum - Family	\$12,300	
Inpatient Hospital Deductible	Not applicable	