2020 NJ State Health Benefits Program (SHBP)
Local Government Employee Plans[1]

Horizon.

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

	OMNIA℠ Tiered Network Option		PPO Plan Options								HMO Option
	OMNIA HEALTH PLAN		NJ DIRECT	NJ DIRECT2019 (new hires on or after 7/1/19)	NJ DIRECT10	NJ DIRECT15	NJ DIRECT1525	NJ DIRECT2030	NJ DIRECT2035	NJ DIRECT HD1500[2]	NJ DIRECT HD4000[2]	HORIZON HMO
	Tier 1	Tier 2										
IN-NETWORK:												
Service Area Available	NJ only	Nationwide	Nationwide	Nationwide	Nationwide	Nationwide	Nationwide	Nationwide	Nationwide	Nationwide	Nationwide	NJ and contiguous counties
Specialist Referral	No referral required	No referral required	No referral required	No referral required	No referral required	No referral required	No referral required	No referral required	No referral required	No referral required	No referral required	Referral required
Deductible[3]												
Individual	$0	$1,500	$0	$100	$0	$0	$0	$0	$200	$1,500[4]	$4,000[4]	See DME
Family	$0	$3,000	$0	n/a	$0	$0	$0	$0	$500	$3,000[4]	$8,000[4]	See DME
Coinsurance	0%	20% after deductible	10%[5]	10% after deductible[5]	10%[5]	10%[5]	10%[5]	10%[5]	20% after deductible	20% after deductible[4]	20% after deductible[4]	0%
Coinsurance Out-of-Pocket Maximum												
Individual	n/a	n/a	$800	$800	n/a	$400	$400	$800	$2,000	$1,000	$1,000	n/a
Family	n/a	n/a	$2,000	$2,000	n/a	$1,000	$1,000	$2,000	$5,000	$2,000	$2,000	n/a
Total Out-of-Pocket Maximum (Copay+Deductible+Coinsurance)												
Individual	$2,500	$4,500	$6,520	$6,520	$400	$6,520	$6,520	$6,520	$6,520	$2,500[4]	$5,000[4]	$6,520
Family	$5,000	$9,000	$13,040	$13,040	$1,000	$13,040	$13,040	$13,040	$13,040	$5,000[4]	$10,000[4]	$13,040
HEALTH CARE SERVICES												
Primary Care Office Visit	$5	$20	$15	$15	$10	$15	$15	$20	$20	20% after deductible	20% after deductible	$10
Annual Routine Physical (In-Network Only)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Specialist Office Visit	$15	$30	$15	$15	$10	$15	$25	$30/adult, $20/child[6]	$35	20% after deductible	20% after deductible	$10
Annual Routine Vision (In-Network Only)	$15	$30	$15	$15	$10	$15	$25	$30/adult, $20/child[6]	$35	20% after deductible	20% after deductible	$10
Chiropractic[7]	$15	$30	$15	$15	$10	$15	$25	$30/adult, $20/child[6]	$35	20% after deductible	20% after deductible	$10
Physical/Occupational/Speech Therapy[8]	$5 office visit/ $15 outpatient facility	$20 office visit/ 20% after deductible at an outpatient facility	$15	$15	$10	$15	$25	$30/adult, $20/child[6]	$35 office visit/ 20% after deductible at an outpatient facility	20% after deductible	20% after deductible	$10
DIAGNOSTIC LABORATORY[9]/RADIOLOGY/ADVANCED IMAGING												
Outpatient Laboratory/Radiology/Advanced Imaging	$15	20% after deductible	$0	$0	$0	$0	$0	$0	20% after deductible	20% after deductible	20% after deductible	$0
Freestanding Laboratory/Radiology/Advanced Imaging	$0	$0	$0	$0	$0	$0	$0	$0	20% after deductible	20% after deductible	20% after deductible	$0
EMERGENCY/URGENT MEDICAL SERVICES												
Urgent Care Center	$15	$30	$15	$15	$10	$15	$25	$30/adult, $20/child[6]	$35	20% after deductible	20% after deductible	$10
Emergency Room	$100	$100	$150[10]	$150[10]	$75[10]	$100[10]	$100[10]	$125	$300	20% after deductible	20% after deductible	$85[10]
Ambulance	$0	$0	10%	10% after deductible	10%	10%	10%	10%	20% after deductible	20% after deductible	20% after deductible	$0
OTHER SERVICES												
Inpatient Facility	$150 per admission[11]	20% after deductible	$0	$0	$0	$0	$0	$0	20% after deductible	20% after deductible	20% after deductible	$0
Outpatient Facility	$150	20% after deductible	$0	$0	$0	$0	$0	$0	20% after deductible	20% after deductible	20% after deductible	$0
Outpatient Behavioral Health	$15	$30 office visit/ 20% after deductible at an outpatient facility	$15	$15	$10	$15	$25	$30/adult, $20/child[6]	$35 office visit/ 20% after deductible at an outpatient facility	20% after deductible	20% after deductible	$10
Durable Medical Equipment (DME)	$0	$0	10%	10% after deductible	10%	10%	10%	10%	20% after deductible	20% after deductible	20% after deductible	$100 deductible, then covered in full
OUT-OF-NETWORK:[12]												
Deductible - Individual	No out-of-network benefits		$400	$400	$100	$100	$100	$200	$800	See in-network deductible[13]	See in-network deductible[13]	No out-of-network benefits
Deductible - Family			$1,000	$1,000	$250	$250	$250	$500	$2,000	See in-network deductible[13]	See in-network deductible[13]	
Coinsurance after Deductible			30%	30%	20%	30%	30%	30%	40%	40%	40%	
Out-of-Pocket Coinsurance Maximum - Individual			$2,000	$2,000	$2,000	$2,000	$2,000	$5,000	$6,500	$3,500	$6,000	
Out-of-Pocket Coinsurance Maximum - Family			$5,000	$5,000	$5,000	$5,000	$5,000	$12,500	$13,000	$7,000	$12,000	
Inpatient Hospital Deductible			$500/stay	$500/stay	$200/stay	$200/stay	$200/stay	$500/stay	$600/stay	n/a	n/a	

1. Check with your employer to find out if all these plans are available to you. You can reference the **HorizonBlue.com/shbpcalculator** to determine your premium contribution.
2. High Deductible Health Plan. NJ DIRECT HD1500 plan includes $300 Health Savings Account funding by employer.
3. Deductible applies to all services that require a coinsurance.
4. Includes eligible prescription cost share.
5. On select services (durable medical equipment, prosthetics, orthotics, oxygen, private duty nursing, ambulance).
6. Under age 26.
7. Chiropractic: Horizon HMO: 20 visits per calendar year. OMNIA Health Plan: 25 visits per calendar year. All other plans: 30 visits per calendar year.
8. 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.
9. Laboratory services must be rendered by an in-network participating provider, with some exceptions based on medical policy.
10. Lower copayment applies to children under 19 and physician referrals.
11. $150 per admission does not apply to inpatient childbirth, hospice or inpatient behavioral health/substance use disorder.
12. Out-of-network cost basis: NJ DIRECT and NJ DIRECT2019: 175% of CMS (Centers for Medicare & Medicaid Services) fee schedule. After out-of-pocket maximum is reached annually, behavioral health is reimbursed at 195% CMS fee schedule. This policy applies through 7/1/21. If receiving obstetric services prior to 7/1/19, reimbursement will be 195% of CMS fee schedule through the end of obstetric services. 90% of FAIR Health 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 chiropractic, physical therapy and acupuncture.
13. Out-of-network deductible is combined with in-network deductible.

Retirees: Please visit **state.nj.us/treasury/pensions** for information regarding available retiree plans.

This is not a complete list of all covered services. Exclusions and limitations apply to some services. Visit **state.nj.us/treasury/pensions/member-guidebooks.shtml** for more information.