2023 NJ State Health Benefits Program (SHBP) State and State College/University Employees

Plans for All Other State Members

Plans effective 1/1/2023 (effective 12/31/2022 for biweekly employees)

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

	OMNIA℠ Tiered Network Option		PPO Plan Options								HMO Option
	OMNIA HEALTH PLAN		NJ DIRECT (employees hired prior to 7/1/19)	NJ DIRECT2019 (new hires on or after 7/1/19)	NJ DIRECT15	NJ DIRECT1525	NJ DIRECT2030	NJ DIRECT2035	NJ DIRECT HD1500[1]	NJ DIRECT HD4000[1]	HORIZON HMO
	Tier 1	Tier 2									
IN-NETWORK (IN)											
Service Area Available	NJ only	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	Referral required
Deductible[2]											
Individual	$0	$1,500	$0	$100	$0	$0	$0	$200	$1,500[3]	$4,000[3]	See DME
Family	$0	$3,000	$0	Not applicable	$0	$0	$0	$500	$3,000[3]	$8,000[3]	See DME
Coinsurance	0%	20% after deductible	10%[4]	10% after deductible[4]	10%[4]	10%[4]	10%[4]	20% after deductible	20% after deductible[3]	20% after deductible[3]	0%
Coinsurance Out-of-Pocket Maximum											
Individual	Not applicable	$4,500	$800	$800	$400	$400	$800	$2,000	$1,000	$1,000	Not applicable
Family	Not applicable	$9,000	$2,000	$2,000	$1,000	$1,000	$2,000	$5,000	$2,000	$2,000	Not applicable
Total Out-of-Pocket Maximum (Copay+Deductible+Coinsurance)											
Individual	$2,500	$4,500	$7,280	$7,280	$7,280	$7,280	$7,280	$7,280	$2,500[3]	$5,000[3]	$7,280
Family	$5,000	$9,000	$14,560	$14,560	$14,560	$14,560	$14,560	$14,560	$5,000[3]	$10,000[3]	$14,560
HEALTH CARE SERVICES											
Primary Care Office Visit	$5	$20	$15	$15	$15	$15	$20	$20	20% after deductible	20% after deductible	$15
Annual Routine Physical (In-Network Only)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Direct Primary Care (DPC) Doctors Office	$0	$0	$0	$0	$0	$0	$0	$0	Not available	Not available	Not available
First Responders Docs (FRDOCS)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Horizon CareOnline (Telemedicine)	Cost share may apply	Cost share may apply	Cost share may apply	Cost share may apply	Cost share may apply	Cost share may apply	Cost share may apply	Cost share may apply	Cost share may apply	Cost share may apply	Cost share may apply
Specialist Office Visit	$20	$35	$30	$30	$15	$25	$30/adult, $20/child[5]	$35	20% after deductible	20% after deductible	$30
Annual Routine Vision (In-Network Only)	$20	$35	$30	$30	$15	$25	$30/adult, $20/child[5]	$35	20% after deductible	20% after deductible	$30
Chiropractic[6]	$20	$35	$30	$30	$15	$25	$30/adult, $20/child[5]	$35	20% after deductible	20% after deductible	$30
Physical/Occupational/Speech Therapy[7]	$20 office visit/ $20 outpatient facility	$35 office visit/ 20% after deductible at an outpatient facility	$30	$30	$15	$25	$30/adult, $20/child[5]	$35 office visit/ 20% after deductible at an outpatient facility	20% after deductible	20% after deductible	$30
DIAGNOSTIC LABORATORY[8]/RADIOLOGY/ADVANCED IMAGING											
Outpatient Laboratory/Radiology/Advanced Imaging	$20	20% after deductible	$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	20% after deductible	20% after deductible	20% after deductible	$0
EMERGENCY/URGENT MEDICAL SERVICES											
Urgent Care Center	$35	$50	$45	$45	$15	$25	$30/adult, $20/child[5]	$35	20% after deductible	20% after deductible	$45
Emergency Room	$100	$100	$150[9]	$150[9]	$100[9]	$100[9]	$125	$300	20% after deductible	20% after deductible	$100[9]
Ambulance	$0	$0	10%	10% after deductible	10%	10%	10%	20% after deductible	20% after deductible	20% after deductible	$0
OTHER SERVICES											
Inpatient Facility	$150 per admission[10]	20% after deductible	$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	20% after deductible	20% after deductible	20% after deductible	$0
Outpatient Behavioral Health	$20	$35 office visit/ 20% after deductible at an outpatient facility	$30	$30	$15	$25	$30/adult, $20/child[5]	$35 office visit/ 20% after deductible at an outpatient facility	20% after deductible	20% after deductible	$30
Durable Medical Equipment (DME)	$0	$0	10%	10% after deductible	10%	10%	10%	20% after deductible	20% after deductible	20% after deductible	$100 deductible, then covered in full
OUT-OF-NETWORK (OON)[11]											
Deductible - Individual	No out-of-network benefits		$400	$400	$100	$100	$200	$800	See in-network deductible[12]	See in-network deductible[12]	No out-of-network benefits
Deductible - Family			$1,000	$1,000	$250	$250	$500	$2,000	See in-network deductible[12]	See in-network deductible[12]	
Coinsurance after Deductible			30%	30%	30%	30%	30%	40%	40%	40%	
Out-of-Pocket Coinsurance Maximum - Individual			$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	$12,500	$13,000	$7,000	$12,000	
Inpatient Hospital Deductible			$500/stay	$500/stay	$200/stay	$200/stay	$500/stay	$600/stay	Not applicable	Not applicable	

1. High Deductible Health Plan. NJ DIRECT HD1500 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. 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.
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 **nj.gov/treasury/pensions/member-guidebooks.shtml** for more information.
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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