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

Plans for CWA and Union Negotiated 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	
	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 Docs (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 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/ 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 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. 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 HD1500[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	$1,500[3]
Family	$0	Not applicable	$3,000[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	$7,280	$7,280	$2,500[3]
Family	$14,560	$14,560	$5,000[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 Docs (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	$3,500
Out-of-Pocket Coinsurance Maximum - Family	$5,000	$5,000	$7,000
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 the **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 HD4000[1]	HORIZON HMO
IN-NETWORK (IN)		
Service Area Available	Nationwide	NJ and contiguous counties
Specialist Referral	No referral required	Referral required
Deductible[2]		
Individual	$4,000[3]	See DME
Family	$8,000[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	$5,000[3]	$7,280
Family	$10,000[3]	$14,560
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 Docs (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	$6,000	
Out-of-Pocket Coinsurance Maximum - Family	$12,000	
Inpatient Hospital Deductible	Not applicable	