

PLAN	TRADITIONAL ¹	Proposed PPO		NJ PLUS	
		In-network	Out-of-network	In-network	Out-of-network ¹
SERVICE AREA	Unrestricted	Potentially nationwide	Unrestricted	All of NJ and FL; Parts of NY and PA	Unrestricted
HOSPITAL INPATIENT	100% for up to 365 days; day 366+ at 80% after deductible. Includes pre-certification.	100% Subject to pre-certification.	70% after \$200 per hospital stay deductible Subject to pre-certification.	100% Subject to pre-certification.	70% after \$200 per hospital stay deductible Subject to pre-certification.
SKILLED NURSING FACILITY	100% for up to 30 days per confinement	100% up to 120 days per calendar year	70% for up to 60 days per calendar year	100% up to 120 days per calendar year	70% for up to 60 days per calendar year
HOSPITAL PRE-ADMISSION TESTING	100%	100%	70% after deductible	100%	70% after deductible
PHYSICIAN (SURGERY)	Basic benefit at 100%; balance at 80% after deductible	100%	70% after deductible	100%	70% after deductible
PHYSICIAN (OFFICE VISITS)	80% after deductible; No coverage for wellness care.	100% after \$15 copayment per visit	70% after deductible; No coverage for wellness care	100% after \$10 copayment per visit; PCP referral required for Specialists visits and some treatments.	70% after deductible; No coverage for wellness care
CHIROPRACTIC	80% after deductible for up to 30 visits per calendar year.	100% after \$15 per visit copayment; 30 visits per calendar year	70% after deductible for up to 30 visits per calendar year combined in-network and out-of-network	100% after \$10 per visit copayment; 30 visits per calendar year; no PCP referral required	70% after deductible for up to 30 visits per calendar year combined in-network and out-of-network
HOSPITAL EMERGENCY ROOM ²	100% for accidental injury; 80% for all others after deductible	100% after \$50 copayment if reported within 48 hours	100% after \$50 copayment if reported within 48 hours; if not reported within 48 hours, subject to deductible and coinsurance	100% after \$25 copayment if reported to PCP and/or NJ PLUS within 48 hours	100% after \$25 copayment if reported to PCP and/or NJ PLUS within 48 hours; if not reported within 48 hours, subject to deductible and coinsurance
ACCIDENT/NON-ACCIDENT CHARGES	All physician fees are paid at 80% after deductible				
IMMUNIZATIONS	Not covered	100% after \$15 copayment per visit (except for travel and/or job related)	70% for children under 12 months, after deductible	100% after \$10 copayment per visit (except for travel and/or job related)	70% for children under 12 months, after deductible
MATERNITY	Basic benefits at 100%; balance at 80% after deductible	\$15 copayment for first prenatal office visit then 100% covered	70% after deductible	\$10 copayment for first prenatal office visit then 100% covered	70% after deductible
PHYSICAL EXAMS	Not covered	100% after \$15 copayment per visit	Not covered	100% after \$10 copayment per visit	Not covered
WELL BABY	Not covered	100% after \$15 copayment per visit	Not covered	100% after \$10 per visit copayment	Not covered

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HOME HEALTH CARE	Services and supplies covered with pre-approval; 60 visits in 61 days at 100%	Services and supplies covered with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered	Services and supplies covered with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered; subject to out-of-network insurance and deductible	Services and supplies covered with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered	Services and supplies covered with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered; subject to out-of-network insurance and deductible
DISEASE MANAGEMENT ⁵ (Voluntary Programs)	Not applicable	Yes	N/A	Asthma, chronic kidney disease, chronic obstructive pulmonary disease, coronary artery disease, diabetes, heart failure	Asthma, chronic kidney disease, chronic obstructive pulmonary disease, coronary artery disease, diabetes, heart failure
PRIVATE DUTY NURSING (Must be Medically Necessary)	Must be ordered by a doctor, provided by an RN or LPN; excludes care that can be provided by hospital staff or home health care aides; excludes assistance with daily activities	Must be ordered by a doctor, provided by an RN or LPN; excludes care that can be provided by hospital staff or home health care aides; excludes assistance with daily activities	Must be ordered by a doctor, provided by an RN or LPN; excludes care that can be provided by hospital staff or home health care aides; excludes assistance with daily activities	Must be ordered by a doctor, provided by an RN or LPN; excludes care that can be provided by hospital staff or home health care aides; excludes assistance with daily activities	Must be ordered by a doctor, provided by an RN or LPN; excludes care that can be provided by hospital staff or home health care aides; excludes assistance with daily activities
INFERTILITY SERVICES (Must be Pre-Authorized)	Diagnosis covered; treatment covered with limitations; subject to a coinsurance and deductible.	Diagnosis covered; treatment covered with limitations	Treatment covered with limitations; subject to out-of-network insurance and deductible	Diagnosis covered; treatment covered with limitations	Treatment covered with limitations; subject to out-of-network insurance and deductible
DEDUCTIBLES (INDIVIDUAL)	\$250 per calendar year	None	\$100 per calendar year; \$200 per hospital admission	None	\$100 per calendar year; \$200 per hospital admission
DEDUCTIBLES (FAMILY MAXIMUM)	Employee \$250 per year, plus \$250 for all other dependents in aggregate. Max - \$500 per family	None	\$250 per calendar year; \$200 per hospital admission	None	\$250 per calendar year; \$200 per hospital admission

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RADIATION/ CHEMOTHERAPY OUTPATIENT	80% after deductible	100%	70% after deductible	100%	70% after deductible
HOSPICE	100%	100%	70% after deductible	100%	70% after deductible
PHYSICAL/SPEECH THERAPY ⁴	80% after deductible	100% after \$15 copayment per visit	70% after deductible	100% after \$10 copayment per visit	70% after deductible
DENTAL COVERAGE	The SHBP Employee Dental Plans are offered to active State employees as a separate dental benefit. These plans fall under one of two basic types: the indemnity style Dental Expense Plan, and one of several Dental Plan Organizations (DPOs). For more information about the SHBP Employee Dental Plans, see the SHBP Employee Dental Plans Member Handbook				
LAB TESTS	80% after deductible; some charges paid at 100%	100%	70% after deductible	100%	70% after deductible
PRESCRIPTION DRUGS	<p>For each 30-day supply received at a retail pharmacy, the copayments will be \$3 for generic drugs and \$10 for brand name prescription drugs. Mail order copayments for up to a 90-day supply are \$5 for generic drugs and \$15 for brand name prescriptions drugs. (If member elects to use a brand name when a generic is available, copay will be \$25 retail, or \$40 mail order, unless the member is medically unable to take the generic.)</p> <p><u>Employee Prescription Drug Plan benefits are available through a participating retail pharmacy or through the Caremark mail order service. For more information about the Employee Prescription Drug Plan, copayment amounts, and specific benefits, see the Employee Prescription Drug Plan Member Handbook</u></p>				
ROUTINE VISION EXAM	None	100% after \$15 copayment; one exam per calendar year, no referral needed	None	100% after \$10 copayment; one exam per calendar year, no referral needed	None
ALCOHOL ABUSE (INPATIENT)	Same as any other illness	Same as any other illness	Same as any other illness	Same as any other illness	Same as any other illness
DRUG ABUSE (INPATIENT)	Same as any other illness	Same as any other illness	Same as any other illness	Same as any other illness	Same as any other illness
ALCOHOL ABUSE (OUTPATIENT)	Same as any other illness	100%, no visit limit	70% after deductible	100%, no visit limit	70% after deductible
DRUG ABUSE (OUTPATIENT)	Same as any other illness	100%, no visit limit	70% after deductible	100%, no visit limit	70% after deductible
MENTAL HEALTH ³ (INPATIENT)	100% for 20 days per calendar year; balance at 80% after deductible up to annual and/or lifetime maximums	100% up to 25 days per calendar year; balance at 90% up to annual and/or lifetime maximums	50 days per calendar year at 50% after deductible up to annual lifetime maximums	100% up to 25 days per calendar year; balance at 90% up to annual and/or lifetime maximums	50 days per calendar year at 50% after deductible up to annual lifetime maximums
MENTAL HEALTH ³ (OUTPATIENT)	80% after deductible up to annual and/or lifetime maximums	90% up to annual and/or lifetime maximums	70% after deductible up to annual and/or lifetime maximums	90% up to annual and/or lifetime maximums	70% after deductible up to annual and/or lifetime maximums

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MAXIMUM OUT-OF-POCKET (INDIVIDUAL)	\$400 per calendar year coinsurance + \$250 deductible	\$400 per calendar year (coinsurance only)	\$2,000 per calendar year (coinsurance only)	\$400 per calendar year (coinsurance only)	\$2,000 per calendar year (coinsurance only)
MAXIMUM OUT-OF-POCKET (FAMILY)	\$400 X number of dependents + deductibles of \$250 for employee + \$250 for all other dependents in aggregate	\$1,000 per calendar year (coinsurance only)	\$5,000 per calendar year (coinsurance only)	\$1,000 per calendar year (coinsurance only)	\$5,000 per calendar year (coinsurance only)
MAXIMUM PLAN COVERED EXPENSES ANNUAL/LIFETIME	\$1,000,000 lifetime (major medical expense only); \$10,000 annual mental health - \$20,000 lifetime mental health; up to \$2,000 restoration feature each year, up to \$20,000 ³	Unlimited; \$15,000 annual mental health; \$50,000 lifetime mental health; up to \$2,000 restoration feature each year, up to \$50,000 ³	\$1,000,000 lifetime (major medical expense only); \$15,000 annual mental health; \$50,000 lifetime mental health; up to \$2,000 restoration feature each year up to \$50,000 ³	Unlimited; \$15,000 annual mental health; \$50,000 lifetime mental health; up to \$2,000 restoration feature each year, up to \$50,000 ³	\$1,000,000 lifetime (major medical expense only); \$15,000 annual mental health; \$50,000 lifetime mental health; up to \$2,000 restoration feature each year up to \$50,000 ³

¹Benefits, excluding hospital expenses, are based on the Horizon's discounted provider network allowance or the "reasonable and customary" fee schedule at the 90% percentile. Some State employees may not be eligible for enrollment in the Traditional Plan.

²NJ PLUS requires notice to the PCP within 48 hours of the incident. Copayment waived if admitted.

³Biologically-based mental health conditions are treated like any other illness and not subject to annual or lifetime mental health dollar maximums or separate mental

⁴Speech therapy limited to: restoration after a loss or impairment of a demonstrated previous ability to speak; develop or improve speech after surgical correction of a

⁵Most disease management programs provide educational materials, and in some cases, individualized case management for members with an emphasis on health