

STATE HEALTH BENEFITS PROGRAM

# PLAN COMPARISON SUMMARY

## FOR LOCAL EDUCATION EMPLOYEES

EFFECTIVE APRIL 1, 2008

The State Health Benefits Program *Plan Comparison Summary* provides a way for employees to compare the benefits of the medical plans offered by the State Health Benefits Program (SHBP). If you are new to the SHBP, or a SHBP member who is considering a different medical plan, the *Plan Comparison Summary* is a useful resource for selecting a plan. For members who want to know more about their current plan, the *Plan Comparison Summary* is a quick reference to the services offered.

The following sections summarize SHBP plan designs and general policies of the SHBP. Inside, the comparison chart summarizes the benefits each plan provides for specified services.

### SHBP MEDICAL PLANS

The SHBP offers Local Education employees the choice of a Preferred Provider Organization, with two options known as **NJ DIRECT10** and **NJ DIRECT15** (administered for the SHBP by Horizon Blue Cross Blue Shield of New Jersey), and two HMO plans — **Aetna HMO** and **CIGNA HealthCare**.

All SHBP medical plans are managed care plans, meaning that they provide coverage for preventive care such as annual checkups and screening tests, well-baby visits, and immunizations, in the hope of avoiding serious illness and more costly treatment.

**NJ DIRECT10** and **NJ DIRECT15** provide both *in-network* and *out-of-network* medical care. Under **NJ DIRECT10** and **NJ DIRECT15**, members may see any physician, nationwide, and do not need to select a Primary Care Physician (PCP) for in-network care.

In-network care is provided through a network of providers that includes internists, general practitioners, specialists, pediatricians, and hospitals.

No referrals are needed for visits to a specialist. If the physician participates in the Horizon BCBSNJ Managed Care Network, the member only pays the appropriate copayment<sup>1</sup>. Members living outside of New Jersey can utilize physicians participating in the national Blue Cross Blue Shield Network. In-network hospital admissions are also covered in full<sup>2</sup>.

If the physician *does not* participate in the Horizon BCBSNJ Managed Care Network or the national network, the services will be considered *out-of-network*. Contact your doctor to see if he or she participates in the Horizon BCBSNJ Managed Care or national network. To find current participating physicians in New Jersey, use the SHBP Unified Provider Directory. To find a participating physician outside of New Jersey, contact Horizon BCBSNJ directly. Plan telephone numbers and Web site addresses are listed on the enclosed comparison chart.

Out-of-network benefits provide reimbursement for eligible services rendered for the treatment of illness and injury. Most out-of-network care is reimbursed at a percentage of “reasonable and customary” allowances after a member’s annual deductible is met.

**NJ DIRECT10** and **NJ DIRECT15** include annual maximum out-of-pocket amounts. This means that when a member’s, or family’s, out-of-pocket maximum is reached, covered benefits are paid at 100 percent of the allowance through the remainder of the calendar year<sup>2</sup>.

There is no coordination of benefits between **NJ DIRECT10** and **NJ DIRECT15**.

**Aetna HMO** and **CIGNA HealthCare** have expanded networks that provide services nationwide. When you enroll in an HMO you must select a Primary Care  
*(continued inside)*

<sup>1</sup> Certain in-network covered benefits require 10% member coinsurance.

<sup>2</sup> Certain services may require pre-certification from Horizon BCBSNJ. Services that require a pre-certification, but are not pre-certified, will be paid at out-of-network benefit levels and will not count towards out-of-pocket maximums.

Physician (PCP) from a group of participating providers contracted by the HMO.

All services, except emergencies and as indicated on the enclosed comparison chart, are coordinated through your PCP. If you require the care of a specialist, your PCP will refer you to a specialist who participates in the HMO network. Electronic referrals are used by the HMOs and, therefore, no paperwork is required. Specialist services rendered without a valid referral, or by a provider who does not participate in the HMO (except for emergencies), will not be paid by the HMO.

HMOs have no deductibles or claim forms to file, however, you are required to pay a copayment for visits to your PCP or a referred specialist. There are no out-of-network benefits, or out-of-pocket maximum amounts under an HMO plan.

If you are considering an HMO, contact your doctor's office to see if they participate in the HMO you have selected. To find current participating physicians in New Jersey, use the SHBP Unified Provider Directory. To find a participating physician outside of New Jersey, contact the HMO directly. Plan telephone numbers and Web site addresses are listed on the enclosed comparison chart.

#### DEFINITIONS

**A copayment** is the fee paid by the member to the in-network physician at the time covered services are rendered.

**Coinsurance** is the portion of the eligible charge that is the member's responsibility for out-of-network and some in-network services (durable medical equipment and ambulance). When utilizing out-of-network providers, charges above the "reasonable and customary" allowance are the member's responsibility but are not considered "coinsurance" for the purposes of out-of-pocket maximums.

**Pre-certification** requires that the member (or the treating physician/facility) receive prior authorization from the medical plan to determine medical necessity before certain services are provided. Some examples of services that require pre-certification are inpatient admissions, reconstructive procedures, durable medical equipment purchases, specialty pharmaceuticals, hospice, and home health care. A detailed list is available from your medical plan.

#### DUAL HMO ENROLLMENT IS PROHIBITED

State statute specifically prohibits two employees/retirees who are both enrolled in the SHBP and who are married to each other, civil union partners, or eligible domestic partners from enrolling under both of the SHBP's HMO plans. One member may belong to an HMO as an employee or as a dependent but not as both.

For example, if two members are married to each other, each may enroll for single coverage under each of the HMOs, or one member can enroll the other as a dependent under an HMO if the other person enrolls in NJ DIRECT10 or NJ DIRECT15.

Furthermore, two SHBP members cannot both cover the same children as dependents under both of the SHBP HMO plans.

In cases of divorce, dissolution of a civil union or domestic partnership, or single parent coverage of dependents, there is no coordination of benefits under two HMO plans.

#### AUDIT OF DEPENDENT COVERAGE

Periodically, the SHBP performs an audit using a random sample of members to determine if dependents are eligible under plan provisions. Proof of dependency such as a marriage, civil union, or birth certificate is required. Coverage for ineligible dependents will be terminated. Failure to respond to the audit will result in the termination of dependents from SHBP coverage and may include financial restitution for claims paid.

#### HEALTH CARE FRAUD

Health care fraud is an intentional deception or misrepresentation that results in an unauthorized benefit to a member or to some other person. Any individual who willfully and knowingly engages in an activity intended to defraud the New Jersey State Health Benefits Program will face disciplinary action that could include termination of employment and may result in prosecution. Any member who receives monies fraudulently from a health plan will be required to fully reimburse the plan.

#### MORE INFORMATION

For more information about eligibility and enrollment in the SHBP, see the *NJ DIRECT* or *HMO Member Handbooks* — available from the Division of Pensions and Benefits, or over the Internet at:

[www.state.nj.us/treasury/pensions/shbp.htm](http://www.state.nj.us/treasury/pensions/shbp.htm)

# NEW JERSEY STATE HEALTH BENEFITS PROGRAM COMPARISON CHART FOR LOCAL EDUCATION EMPLOYEES

| PLAN NAME<br>TELEPHONE<br>NUMBER<br>and WEB SITE                                  | #019 - AETNA HMO<br>1-877-STATE NJ<br>(1-877-782-8365)<br>www.aetna.com/staterj    | #020 - CIGNA<br>HEALTHCARE<br>1-800-564-7642<br>www.cigna.com/stateofnj            | #050 - NJ DIRECT10 / #150 - NJ DIRECT15<br>1-800-414-SHBP<br>(1-800-414-7427)<br>www.horizonblue.com/shbp |   |
|---|--|--|---|---|
|   |  |  | IN-NETWORK <sup>1</sup>   | OUT-OF-NETWORK <sup>1</sup>   |
| <b>SERVICE AREAS</b>  | Nationwide   | Nationwide   | Nationwide  | Nationwide  |
| <b>PRIMARY AND PREVENTIVE CARE</b>  |  |  |   |   |
| <b>PHYSICIAN (OFFICE VISITS)</b>  | 100% after \$10 copayment per visit  | 100% after \$10 copayment per visit  | 100% after \$10 / \$15 copayment per visit  | 80% / 70% after deductible; no coverage for wellness care                   |
| <b>ANNUAL ROUTINE PHYSICAL EXAMS</b>  | 100% after \$10 copayment per visit  | 100% after \$10 copayment per visit  | 100% after \$10 / \$15 copayment per visit  | Not covered   |
| <b>ROUTINE CHILD AND WELL-BABY CARE</b>   | 100% after \$10 copayment per visit  | 100% after \$10 copayment per visit  | 100% after \$10 / \$15 copayment per visit  | Not covered   |
| <b>IMMUNIZATIONS (EXCEPT FOR TRAVEL AND/OR JOB RELATED)</b>                       | 100% after \$10 copayment per visit  | 100% after \$10 copayment per visit  | 100% after \$10 / \$15 copayment per visit  | Not covered except for children under 12 months; 80% / 70% after deductible |
| <b>ANNUAL ROUTINE GYNECOLOGICAL EXAMS</b>   | 100% after \$10 copayment per visit (no referral needed if using network provider) | 100% after \$10 copayment per visit (no referral needed if using network provider) | 100% after \$10 / \$15 copayment per visit  | 80% / 70% after deductible  |
| <b>ANNUAL ROUTINE MAMMOGRAM (ONE ANNUAL MAMMOGRAM FOR WOMEN AGE 40 AND OVER)</b>  | 100% after \$10 copayment per visit (no referral needed if using network provider) | 100%   | 100% after \$10 / \$15 copayment per visit  | 80% / 70% after deductible  |
| <b>PROSTATE SCREENING (ONE ANNUAL PROSTATE SCREENING FOR MEN AGE 40 AND OVER)</b> | 100% after \$10 copayment per visit  | 100% after \$10 copayment per visit  | 100% after \$10 / \$15 copayment per visit  | Not covered   |
| <b>ANNUAL ROUTINE EYE EXAMINATIONS</b>  | 100% after \$10 copayment per visit (no referral needed if using network provider) | 100% after \$10 copayment per visit (no referral needed if using network provider) | 100% after \$10 / \$15 copayment per visit  | Not covered   |
| <b>HEARING AIDS</b>   | Not covered  | Not covered  | Not covered   | Not covered   |

<sup>1</sup> In-network copayment \$10 for NJ DIRECT10 and \$15 for NJ DIRECT15; Out-of-Network reimbursement 80% for NJ DIRECT10 and 70% for NJ DIRECT15. Benefits, excluding hospital expenses, are based on the Horizon BCBSNJ discounted provider network allowance or the "reasonable and customary" fee schedule based at the 90th percentile.

| PLAN NAME<br>TELEPHONE<br>NUMBER<br>and WEB SITE  | #019 - AETNA HMO<br>1-877-STATE NJ<br>(1-877-782-8365)<br>www.aetna.com/statenj  | #020 - CIGNA<br>HEALTHCARE<br>1-800-564-7642<br>www.cigna.com/stateofnj  | #050 - NJ DIRECT10 / #150 - NJ DIRECT15<br>1-800-414-SHBP<br>(1-800-414-7427)<br>www.horizonblue.com/shbp   |  |
|---|--|--|---|--|
|   |  |  | IN-NETWORK <sup>1</sup>   | OUT-OF-NETWORK <sup>1</sup>  |
| <b>SPECIALTY AND<br/>OUTPATIENT CARE</b>  |  |  |   |  |
| <b>SPECIALIST OFFICE<br/>VISITS</b>   | 100% after \$10<br>copayment per visit;<br>PCP referral required   | 100% after \$10<br>copayment per visit;<br>PCP referral required   | 100% after \$10 / \$15<br>copayment per visit   | 80% / 70% after<br>deductible; no coverage<br>for wellness care  |
| <b>ALLERGY TESTING</b>  | 100% after \$10<br>copayment per visit   | 100% after \$10<br>copayment per visit   | 100% after \$10 / \$15<br>copayment per visit   | 80% / 70% after<br>deductible  |
| <b>ALLERGY TREATMENT<br/>ROUTINE INJECTIONS</b>   | 100% after \$10<br>copayment per visit   | 100% after \$10<br>copayment per visit   | 100% after \$10 / \$15<br>copayment per visit   | 80% / 70% after<br>deductible  |
| <b>PRENATAL CARE/<br/>MATERNITY CARE</b>  | \$10 copayment for first<br>prenatal office visit then<br>100% covered.<br>Beginning Right<br>Maternity Program<br>- a voluntary prenatal<br>education program | \$10 copayment for first<br>prenatal office visit then<br>100% covered.<br>Healthy Babies - a<br>voluntary prenatal<br>education program | \$10 / \$15 copayment for<br>first prenatal office visit<br>then 100% covered.<br>Precious Additions - a<br>voluntary prenatal<br>education program | 80% / 70% after<br>deductible  |
| <b>INFERTILITY<br/>SERVICES<br/>(MUST BE<br/>PRE-CERTIFIED)</b>   | Diagnosis covered<br>after \$10 copayment;<br>treatment covered<br>with limitations after<br>\$10 copayment  | Diagnosis covered<br>after \$10 copayment;<br>treatment covered<br>with limitations after<br>\$10 copayment                              | Diagnosis covered<br>after \$10 / \$15<br>copayment;<br>treatment covered<br>with limitations after<br>\$10 / \$15 copayment                        | Diagnosis covered<br>at 80% / 70% after<br>deductible; treatment<br>covered with limitations<br>at 80% / 70% after<br>deductible |
| <b>OUTPATIENT<br/>FACILITY VISITS</b>   |  |  |   |  |
| <b>CHEMOTHERAPY</b>   | 100% after \$10<br>copayment per visit   | 100% after \$10<br>copayment per visit   | 100%; no copayment  | 80% / 70% after<br>deductible  |
| <b>RADIATION THERAPY</b>  | 100% after \$10<br>copayment per visit   | 100% after \$10<br>copayment per visit   | 100%; no copayment  | 80% / 70% after<br>deductible  |
| <b>INFUSION THERAPY</b>   | 100% after \$10<br>copayment per visit   | 100% after \$10<br>copayment per visit   | 100% after \$10 / \$15<br>copayment per visit   | 80% / 70% after<br>deductible  |
| <b>X-RAYS AND<br/>LAB TESTS<br/>(OUTPATIENT)</b>  | 100%; no copayment   | 100%; no copayment   | 100%; no copayment  | 80% / 70% after<br>deductible  |
| <b>OUTPATIENT<br/>REHABILITATION<br/>(OTHER THAN<br/>PHYSICAL THERAPY,<br/>OCCUPATIONAL THERAPY,<br/>SPEECH THERAPY<br/>AND CARDIAC<br/>REHABILITATION)</b> | 100%; no copayment;<br>limit of 60 visits per<br>calendar year   | 100%; no copayment;<br>limit of 60 visits per<br>calendar year   | 100%; no copayment;<br>limit of 60 visits per<br>calendar year  | 80% / 70% after<br>deductible  |

<sup>1</sup> In-network copayment \$10 for NJ DIRECT10 and \$15 for NJ DIRECT15; Out-of-Network reimbursement 80% for NJ DIRECT10 and 70% for NJ DIRECT15. Benefits, excluding hospital expenses, are based on the Horizon BCBSNJ discounted provider network allowance or the "reasonable and customary" fee schedule based at the 90th percentile.

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|--|---|---|---|--|
|  |   |   | IN-NETWORK <sup>1</sup>   | OUT-OF-NETWORK <sup>1</sup>  |
| <b>SPECIALTY AND<br/>OUTPATIENT CARE</b>   |   |   |   |  |
| <b>OUTPATIENT THERAPY<br/>(SPEECH,<sup>2</sup><br/>OCCUPATIONAL,<br/>PHYSICAL)</b> | 100%; after \$10<br>copayment per visit;<br>limit of 60 visits<br>per condition<br>per calendar year  | 100%; after \$10<br>copayment per visit;<br>limit of 60 visits<br>per condition<br>per calendar year  | 100% after \$10 / \$15<br>copayment per visit   | 80% / 70% after<br>deductible  |
| <b>OUTPATIENT CARDIAC<br/>REHABILITATION<br/>THERAPY</b>                           | 100% after \$10<br>copayment per visit  | 100% after \$10<br>copayment per visit  | 100% after \$10 / \$15<br>copayment per visit   | 80% / 70% after<br>deductible  |
| <b>CHIROPRACTIC CARE</b>   | 100%; after \$10<br>copayment per visit;<br>limit of 20 visits<br>per calendar year;<br>PCP referral required   | 100%; after \$10<br>copayment per visit;<br>limit of 20 visits<br>per calendar year   | 100% after \$10 / \$15<br>copayment per visit;<br>limit of 30 visits per<br>calendar year;<br>combined in-network<br>and out-of-network                                   | 80% / 70% after<br>deductible for<br>up to 30 visits per<br>calendar year<br>combined in-network<br>and out-of-network   |
| <b>HOME HEALTH<br/>CARE</b>  | Services and supplies<br>covered at 100% with<br>pre-approval; prior<br>inpatient hospital<br>stay not required;<br>nursing home care<br>or custodial care<br>not covered | Services and supplies<br>covered at 100% with<br>pre-approval; prior<br>inpatient hospital<br>stay not required;<br>nursing home care<br>or custodial care<br>not covered | Services and supplies<br>covered at 100% with<br>pre-approval; prior<br>inpatient hospital<br>stay not required;<br>nursing home care<br>or custodial care<br>not covered | Services and supplies<br>covered at 80% / 70%<br>after deductible with<br>pre-approval; prior<br>inpatient hospital<br>stay not required;<br>nursing home care<br>or custodial care<br>not covered |
| <b>HOSPICE CARE<br/>(OUTPATIENT)</b>   | 100%; no copayment  | 100%; no copayment  | 100%; no copayment  | 80% / 70% after<br>deductible  |
| <b>DURABLE MEDICAL<br/>EQUIPMENT (DME)</b>   | \$100 deductible; then<br>100% for rest of<br>calendar year   | \$100 deductible; then<br>100% for rest of<br>calendar year   | 90%; no copayment   | 80% / 70% after<br>deductible  |
| <b>PROSTHETIC<br/>DEVICES<br/>(MUST BE APPROVED<br/>IN ADVANCE)</b>                | \$100 deductible; then<br>100% for rest of<br>calendar year; combined<br>deductible with Durable<br>Medical Equipment   | \$100 deductible; then<br>100% for rest of<br>calendar year; combined<br>deductible with Durable<br>Medical Equipment   | 90%; no copayment   | 80% / 70% after<br>deductible  |
| <b>INPATIENT SERVICES</b>  |   |   |   |  |
| <b>HOSPITAL<br/>(ROOM AND BOARD AND<br/>OTHER INPATIENT<br/>SERVICES)</b>          | 100%; no copayment  | 100%; no copayment  | 100%; no copayment  | 80% / 70% after<br>deductible  |
| <b>SKILLED NURSING<br/>FACILITIES</b>  | 100%; no copayment;<br>for up to 120 days<br>per calendar year  | 100%; no copayment;<br>for up to 120 days<br>per calendar year  | 100%; no copayment;<br>for up to 120 days<br>per calendar year;<br>combined in-network<br>and out-of-network  | 80% / 70% after<br>deductible; for up to 60<br>days per calendar year;<br>combined in-network<br>and out-of-network  |
| <b>HOSPICE FACILITY</b>  | 100%; no copayment  | 100%; no copayment  | 100%; no copayment  | 80% / 70% after<br>deductible  |
| <b>INPATIENT VISITS</b>  | 100%; no copayment  | 100%; no copayment  | 100%; no copayment  | 80% / 70% after<br>deductible  |

<sup>1</sup> In-network copayment \$10 for NJ DIRECT10 and \$15 for NJ DIRECT15; Out-of-Network reimbursement 80% for NJ DIRECT10 and 70% for NJ DIRECT15. Benefits, excluding hospital expenses, are based on the Horizon BCBSNJ discounted provider network allowance or the "reasonable and customary" fee schedule based at the 90th percentile.

<sup>2</sup> Speech 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 birth defect.

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|--|---|---|---|---|
|  |   |   | IN-NETWORK <sup>1</sup>   | OUT-OF-NETWORK <sup>1</sup>   |
| <b>SURGERY AND ANESTHESIA</b>                    |   |   |   |   |
| <b>INPATIENT SURGERY</b>                         | 100%; no copayment  | 100%; no copayment  | 100%; no copayment  | 80% / 70% after deductible  |
| <b>OUTPATIENT SURGERY</b>                        | 100%; no copayment  | 100%; no copayment  | 100%; no copayment  | 80% / 70% after deductible  |
| <b>MENTAL HEALTH</b>                             |   |   |   |   |
| <b>INPATIENT TREATMENT<sup>3</sup></b>           | 100%; no copayment; up to 35 days per calendar year                             | 100%; no copayment; up to 35 days per calendar year                     | 100%; no copayment; 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 and/or lifetime maximums |
| <b>OUTPATIENT TREATMENT<sup>3</sup></b>          | 100% after \$10 copayment per visit; up to 30 visits per calendar year          | 100% after \$10 copayment per visit; up to 30 visits per calendar year  | 90% up to annual and/or lifetime maximums   | 80% / 70% after deductible up to annual and/or lifetime maximums                        |
| <b>ALCOHOL AND DRUG ABUSE</b>                    |   |   |   |   |
| <b>INPATIENT TREATMENT</b>                       | 100%; no copayment; up to 28 days per occurrence per calendar year              | 100%; no copayment; up to 28 days per occurrence per calendar year      | Same as any other illness   | Same as any other illness   |
| <b>INPATIENT DETOXIFICATION</b>                  | 100%; no copayment  | 100%; no copayment  | Same as any other illness   | Same as any other illness   |
| <b>OUTPATIENT TREATMENT</b>                      | 100%; no copayment; up to 60 visits per calendar year                           | 100%; no copayment; up to 60 visits per calendar year                   | 100%; no copayment; no visit limit  | 80% / 70% after deductible  |
| <b>INPATIENT REHABILITATION</b>                  | 100%; no copayment; up to 28 days per occurrence per calendar year              | 100%; no copayment; up to 28 days per occurrence per calendar year      | Same as any other illness   | Same as any other illness   |
| <b>OUTPATIENT DETOXIFICATION</b>                 | 100%; no copayment  | 100%; no copayment  | Same as any other illness   | Same as any other illness   |

<sup>1</sup> In-network copayment \$10 for NJ DIRECT10 and \$15 for NJ DIRECT15; Out-of-Network reimbursement 80% for NJ DIRECT10 and 70% for NJ DIRECT15. Benefits, excluding hospital expenses, are based on the Horizon BCBSNJ discounted provider network allowance or the "reasonable and customary" fee schedule based at the 90th percentile.

<sup>3</sup> Biologically-based mental health conditions are treated like any other illness and not subject to annual or lifetime mental health dollar maximums or separate mental health visit limits.

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|---|--|--|---|---|
|   |  |  | IN-NETWORK <sup>1</sup>   | OUT-OF-NETWORK <sup>1</sup>   |
| <b>EMERGENCY CARE</b>   |  |  |   |   |
| <b>HOSPITAL<br/>EMERGENCY ROOM<br/>(COPAYMENT WAIVED<br/>IF ADMITTED)</b>                 | 100% after \$35<br>copayment   | 100% after \$35<br>copayment   | 100% after \$25 / \$50 <sup>4</sup><br>copayment  | 100% after \$25 / \$50 <sup>4</sup><br>copayment  |
| <b>AMBULANCE<br/>(FOR EMERGENCY<br/>TRANSPORTATION ONLY)</b>                              | 100%; no copayment   | 100%; no copayment   | 90%; no copayment   | 80% / 70% after<br>deductible   |
| <b>VOLUNTARY<br/>PROGRAMS</b>   |  |  |   |   |
| <b>DISEASE<br/>MANAGEMENT<br/>PROGRAMS<sup>5</sup></b>                                    | Asthma, Chronic Heart<br>Failure, Chronic Hepatitis,<br>Chronic Kidney Disease,<br>Chronic Obstructive<br>Pulmonary Disease,<br>Chron's Disease,<br>Coronary Artery Disease,<br>Diabetes, Gastro<br>Esophageal Reflux,<br>Inflammatory Bowel<br>Disease, Low Back Pain,<br>and Weight Management | Well Aware Program<br>monitored by PCP for<br>chronic conditions like<br>Asthma, Chronic<br>Obstructive Pulmonary<br>Disease, Diabetes,<br>Heart Failure,<br>Hepatitis C, and<br>Low Back Pain | Asthma, Chronic<br>Kidney Disease,<br>Chronic Obstructive<br>Pulmonary Disease,<br>Coronary Artery<br>Disease, Diabetes,<br>Heart Failure,<br>Hepatitis C, Obesity,<br>and Multiple Sclerosis | Asthma, Chronic<br>Kidney Disease,<br>Chronic Obstructive<br>Pulmonary Disease,<br>Coronary Artery<br>Disease, Diabetes,<br>Heart Failure,<br>Hepatitis C, Obesity,<br>and Multiple Sclerosis |
| <b>PLAN DEDUCTIBLES, OUT-OF-POCKET MAXIMUMS, AND<br/>ANNUAL/LIFETIME BENEFIT MAXIMUMS</b> |  |  |   |   |
| <b>DEDUCTIBLES<br/>(INDIVIDUAL)</b>   | None   | None   | None  | \$100 per calendar year   |
| <b>DEDUCTIBLES<br/>(FAMILY<br/>MAXIMUM)</b>   | None   | None   | None  | \$250 per family,<br>per calendar year  |
| <b>MAXIMUM<br/>OUT-OF-POCKET<br/>(INDIVIDUAL)</b>   | No maximum   | No maximum   | \$400 per<br>calendar year<br>(coinsurance and<br>copayments) <sup>6</sup>  | \$2,000 per<br>calendar year<br>(coinsurance only) <sup>6</sup>   |
| <b>MAXIMUM<br/>OUT-OF-POCKET<br/>(FAMILY)</b>   | No maximum   | No maximum   | \$1,000 per<br>calendar year<br>(coinsurance and<br>copayments) <sup>6</sup>  | \$5,000 per<br>calendar year<br>(coinsurance only) <sup>6</sup>   |
| <b>MAXIMUM<br/>PLAN<br/>COVERED<br/>EXPENSES<br/>ANNUAL/LIFETIME</b>                      | Unlimited  | Unlimited  | Unlimited <sup>7</sup>  | \$1,000,000 lifetime <sup>7</sup>   |

<sup>1</sup> In-network copayment \$10 for NJ DIRECT10 and \$15 for NJ DIRECT15; Out-of-Network reimbursement 80% for NJ DIRECT10 and 70% for NJ DIRECT15. Benefits, excluding hospital expenses, are based on the Horizon BCBSNJ discounted provider network allowance or the "reasonable and customary" fee schedule based at the 90th percentile.

<sup>4</sup> NJ DIRECT10 emergency room copayment is \$25; NJ DIRECT15 emergency room copayment is \$50.

<sup>5</sup> Most disease management programs provide educational materials, and in some cases, individualized case management for members with an emphasis on health education and behavior modification.

<sup>6</sup> In-network out-of-pocket expenses apply to out-of-network out-of-pocket maximum under NJ Direct10. Under NJ Direct15, only coinsurance goes toward in-network out-of-pocket expenses.

<sup>7</sup> \$15,000 annual mental health; \$50,000 lifetime mental health. Up to \$2,000 restoration feature each year with a lifetime maximum of \$50,000. Biologically-based mental health conditions are treated like any other illness and not subject to annual or lifetime mental health dollar maximums or separate mental health visit limits.

## PRESCRIPTION DRUG COVERAGE FOR LOCAL EDUCATION EMPLOYEES

Employers have the option of providing the **SHBP Employee Prescription Drug Plan**, or another drug plan, as a separate prescription drug benefit. If the employer provides a separate prescription drug plan to employees, the medical plan will not include any drug coverage.

If no separate prescription drug plan is provided, the medical plan will provide drug coverage as noted below.

| PLAN NAME<br>TELEPHONE NUMBER<br>and WEB SITE   | #019 - AETNA HMO<br>1-877-STATE NJ<br>(1-877-782-8365)<br><a href="http://www.aetna.com/statenj">www.aetna.com/statenj</a> |      | #020 - CIGNA<br>HEALTHCARE<br>1-800-564-7642<br><a href="http://www.cigna.com/stateofnj">www.cigna.com/stateofnj</a> |      | #050 - NJ DIRECT10 / #150 - NJ DIRECT15<br>1-800-414-SHBP<br>(1-800-414-7427)<br><a href="http://www.horizonblue.com/shbp">www.horizonblue.com/shbp</a> |  |
|---|--|------|--|------|---|--|
|   | PHARMACY<br>Copayment for<br>30-day supply   |      | PHARMACY<br>Copayment for<br>30-day supply   |      | IN-NETWORK  | OUT-OF-NETWORK   |
| PRESCRIPTION<br>DRUG <sup>8</sup><br>Benefits for<br>employees<br>without employer<br>prescription<br>drug plan | Generic  | \$5  | Generic  | \$5  | NJ DIRECT10 and<br>NJ DIRECT15<br>90% reimbursement   | NJ DIRECT10 - 80%<br>after deductible<br><br>NJ DIRECT15 - 70%<br>after deductible |
|   | Preferred brand  | \$10 | Preferred brand  | \$10 |   |  |
|   | Other brands   | \$20 | Other brands   | \$20 |   |  |
|   | MAIL ORDER<br>Copayment for<br>90-day supply   |      | MAIL ORDER<br>Copayment for<br>90-day supply   |      |   |  |
|   | Generic  | \$5  | Generic  | \$5  |   |  |
|   | Preferred brand  | \$10 | Preferred brand  | \$10 |   |  |
|   | Other brands   | \$20 | Other brands   | \$20 |   |  |

<sup>8</sup>Certain prescription drugs may require precertification prior to purchase. Please contact your plan for details.

## DENTAL COVERAGE FOR LOCAL EDUCATION EMPLOYEES

Employers have the option of offering the **SHBP Employee Dental Plans**, or another dental plan, as a separate dental benefit.

If provided by your employer, the **SHBP Employee Dental Plans** offer two basic types of plan: the Dental Expense Plan, and a selection of Dental Plan Organizations (DPOs). For more information, see the *SHBP Employee Dental Plans Member Handbook* which is available from your participating employer, from the Division of Pensions and Benefits, or at the SHBP home page at: [www.state.nj.us/treasury/pensions/shbp.htm](http://www.state.nj.us/treasury/pensions/shbp.htm)

If your employer offers another dental plan, contact your human resources representative or benefits administrator for plan information.

## UNIFIED PROVIDER DIRECTORY

The **Unified Provider Directory**, available on the Internet contains current, and comprehensive information about health care providers and facilities that deliver their services through one or more of the SHBP's managed-care plans in New Jersey and selected areas of neighboring states (for other states, contact the medical plan or see the plan's Web site for provider information).

Updated monthly, the Unified Provider Directory information is in an easy to use format and can be reached through the SHBP's home page at: [www.state.nj.us/treasury/pensions/shbp.htm](http://www.state.nj.us/treasury/pensions/shbp.htm)

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This is a summary and not intended to provide total information. Although every attempt at accuracy is made, it cannot be guaranteed.