| PLAN | Proposed PPO | | NJ PLUS | | HMO PLAN (Current Minimum Requirements) |
|---|---|---|---|---|---|
| | In-network | Out-of-network[1] | In-network | Out-of-network[1] | |
| SERVICE AREA | Potentially nationwide | Unrestricted | All of NJ and FL; Parts of NY and PA | Unrestricted | All of NJ and nationwide |
| HOSPITAL INPATIENT | 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. | 100% |
| SKILLED NURSING FACILITY | 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 | 100%; unlimited days |
| HOSPITAL PRE-ADMISSION TESTING | 100% | 70% after deductible | 100% | 70% after deductible | 100% |
| PHYSICIAN (SURGERY) | 100% | 70% after deductible | 100% | 70% after deductible | 100% |
| PHYSICIAN (OFFICE VISITS) | 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 | 100% after $10 copayment per visit |
| CHIROPRACTIC | 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 | 100% for up to 20 visits per year, after $10 per visit copayment; PCP referral required |
| HOSPITAL EMERGENCY ROOM[2] ACCIDENT/NON-ACCIDENT CHARGES | 100% after $50 copayment if reported within 48 hours | 100% after $50 copayment if reported within 48 hours | 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 | 100% after $35 copayment |
| IMMUNIZATIONS | 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 | 100% after $10 copayment per visit (except for travel and/or job related) |
| MATERNITY | $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 | $10 copayment for first prenatal visit then 100% covered |
| PHYSICAL EXAMS | 100% after $15 copayment per visit | Not covered | 100% after $10 copayment per visit | Not covered | 100% after $10 copayment per visit |
| WELL BABY | 100% after $15 copayment per visit | Not covered | 100% after $10 per visit copayment | Not covered | 100% after $10 copayment per visit |

| PLAN | Proposed PPO | | NJ PLUS | | HMO PLAN (Current Minimum Requirements) |
|---|---|---|---|---|---|
| | In-network | Out-of-network[1] | In-network | Out-of-network[1] | |
| RADIATION/ CHEMOTHERAPY OUTPATIENT | 100% | 70% after deductible | 100% | 70% after deductible | 100% after $10 copayment per office visit |
| HOSPICE | 100% | 70% after deductible | 100% | 70% after deductible | 100% |
| PHYSICAL/SPEECH THERAPY[4] | 100% after $15 copayment per visit | 70% after deductible | 100% after $10 copayment per visit | 70% after deductible | 100% after $10 copayment per visit for up to 60 visits per condition per year |
| 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 | 100% | 70% after deductible | 100% | 70% after deductible | 100% |
| PRESCRIPTION DRUGS | **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.)**<br><br>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 | | | | |
| ROUTINE VISION EXAM | 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 | 100% after $10 copayment; exam every 1 to 3 years based on age; no referral needed |
| ALCOHOL ABUSE (INPATIENT) | Same as any other illness | Same as any other illness | Same as any other illness | Same as any other illness | 100% detox; rehab-28 days at 100% per occurrence (additional days available after review.) |
| DRUG ABUSE (INPATIENT) | Same as any other illness | Same as any other illness | Same as any other illness | Same as any other illness | 100% detox; rehab-28 days at 100% per occurrence (additional days available after review.) |
| ALCOHOL ABUSE (OUTPATIENT) | 100%, no visit limit | 70% after deductible | 100%, no visit limit | 70% after deductible | 100% up to 60 visits per calendar year; no copayment |
| DRUG ABUSE (OUTPATIENT) | 100%, no visit limit | 70% after deductible | 100%, no visit limit | 70% after deductible | 100% up to 60 days per calendar year; no copayment |

| PLAN | Proposed PPO | | NJ PLUS | | HMO PLAN (Current Minimum Requirements) |
|---|---|---|---|---|---|
| | In-network | Out-of-network[1] | In-network | Out-of-network[1] | |
| MENTAL HEALTH[3] (INPATIENT) | 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 | 100% up to 35 days per calendar year. |
| MENTAL HEALTH[3] (OUTPATIENT) | 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 | 100% after $10 copayment per visit for up to 30 visits per calendar year. |
| HOME HEALTH CARE | 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 coinsurance 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 coinsurance and deductible | Services and supplies covered with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered |
| DISEASE MANAGEMENT[5] (Voluntary Programs) | 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 | Asthma, chronic heart failure, coronary artery disease, diabetes, low back pain |
| 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 activies | 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 activies | 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 activies | 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 activies | Inpatient hospital care excluded; outpatient care must be authorized by PCP and services rendered by or supervised by a RN |

| PLAN | Proposed PPO | | NJ PLUS | | HMO PLAN (Current Minimum Requirements) |
|---|---|---|---|---|---|
| | In-network | Out-of-network[1] | In-network | Out-of-network[1] | |
| INFERTILITY SERVICES (Must be Pre-Authorized) | Diagnosis covered; treatment covered with limitations | Treatment covered with limitations; subject to out-of-network coinsurance and deductible | Diagnosis covered; treatment covered with limitations | Treatment covered with limitations; subject to out-of-network coinsurance and deductible | Diagnosis covered; treatment covered with limitations |
| DEDUCTIBLES (INDIVIDUAL) | None | $100 per calendar year; $200 per hospital admission | None | $100 per calendar year; $200 per hospital admission | None |
| DEDUCTIBLES (FAMILY MAXIMUM) | None | $250 per calendar year; $200 per hospital admission | None | $250 per calendar year; $200 per hospital admission | None |
| MAXIMUM OUT-OF-POCKET (INDIVIDUAL) | $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) | No maximum |
| MAXIMUM OUT-OF-POCKET (FAMILY) | $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) | No maximum |
| MAXIMUM PLAN COVERED EXPENSES ANNUAL/LIFETIME | 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] | Unlimited |

[1]Benefits, excluding hospital expenses, are based on the "reasonable and customary" fee schedule at the 90% percentile.

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

[3]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.

[4]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.

[5]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.