

STATE HEALTH BENEFITS PROGRAM

PLAN COMPARISON SUMMARY

FOR STATE EMPLOYEES

EFFECTIVE JANUARY 1, 2011

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

MEDICAL PLANS

State employees are offered the choice of a Preferred Provider Organization, **NJ DIRECT15** (administered by Horizon Blue Cross Blue Shield of New Jersey), and two HMO plans — **Aetna HMO** and **CIGNA HealthCare**.

All of the 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 DIRECT15 provides both *in-network* and *out-of-network* medical care. Under 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 copayment¹. 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 full².

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 contact Horizon BCBSNJ directly. Plan telephone numbers and Web site addresses are listed on the comparison charts.

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. Out-of-network hospital admissions are subject to a separate deductible.

NJ DIRECT15 includes 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 year².

Aetna HMO and **CIGNA HealthCare** have expanded networks that provide services nationwide. When you enroll in an HMO you must select a Primary Care Physician (PCP) from a group of participating providers contracted by the HMO.

(continued inside)

¹ Certain in-network covered benefits require 10% member coinsurance.

² 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.

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 (except for durable medical equipment) 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 contact the HMO directly. Plan telephone numbers and Web site addresses are listed on the comparison charts.

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.

MULTIPLE SHBP/SEHBP COVERAGE IS PROHIBITED

State statute specifically prohibits two members who are each enrolled in the SHBP/SEHBP plans from covering each other. Therefore, an eligible individual may only enroll in the SHBP/SEHBP as an employee or retiree, or be covered as a dependent.

in addition, **eligible children** may only be covered by one participating SHBP/SEHBP subscriber.

For example, a husband and wife both have coverage based on their employment and have children eligible for coverage. One may choose Family coverage, making the spouse and children the dependents and ineligible for any other SHBP/SEHBP coverage; or one may choose Single coverage and the spouse may choose Parent and Child(ren) coverage.

AUDIT OF DEPENDENT COVERAGE

Periodically, the Division of Pensions and Benefits 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 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 SHBP 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, see the *NJ DIRECT*, *Aetna HMO*, or *CIGNA HealthCare Member Handbooks* — available over the Internet from the Division of Pensions and Benefits at: www.state.nj.us/treasury/pensions/

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FOR STATE EMPLOYEES

PLAN NAME TELEPHONE NUMBER and WEB SITE	#005 - AETNA HMO 1-877-STATE NJ (1-877-782-8365) www.aetna.com/statenj	#006 - CIGNA HEALTHCARE 1-800-564-7642 www.cigna.com/stateofnj	#150 - NJ DIRECT15 1-800-414-SHBP (1-800-414-7427) www.horizonblue.com/shbp	
			IN-NETWORK	OUT-OF-NETWORK ¹
SERVICE AREAS	Nationwide	Nationwide	Nationwide	Nationwide
PRIMARY AND PREVENTIVE CARE				
PHYSICIAN (OFFICE VISITS)	100% after \$15 copayment per visit	100% after \$15 copayment per visit	100% after \$15 copayment per visit	70% after deductible; no coverage for wellness care
ANNUAL ROUTINE PHYSICAL EXAMS	100% after \$15 copayment per visit	100% after \$15 copayment per visit	100% after \$15 copayment per visit	Not covered
ROUTINE CHILD AND WELL-BABY CARE	100% after \$15 copayment per visit	100% after \$15 copayment per visit	100% after \$15 copayment per visit	Not covered
IMMUNIZATIONS (EXCEPT FOR TRAVEL AND/OR JOB RELATED)	100% after \$15 copayment per visit	100% after \$15 copayment per visit	100% after \$15 copayment per visit	Not covered except for children under 12 months, 70% after deductible
ANNUAL ROUTINE GYNECOLOGICAL EXAMS	100% after \$15 copayment per visit (no referral needed if using network provider)	100% after \$15 copayment per visit (no referral needed if using network provider)	100% after \$15 copayment per visit	70% after deductible
ANNUAL ROUTINE MAMMOGRAM (ONE ANNUAL MAMMOGRAM FOR WOMEN AGE 40 AND OVER)	100%; no copayment (no referral needed if using network provider)	100%; no copayment	100%; no copayment	70% after deductible
PROSTATE SCREENING (ONE ANNUAL PROSTATE SCREENING FOR MEN AGE 40 AND OVER)	100% after \$15 copayment per visit	100% after \$15 copayment per visit	100% after \$15 copayment per visit	Not covered
ANNUAL ROUTINE EYE EXAMINATIONS	100% after \$15 copayment per visit (no referral needed if using network provider)	100% after \$15 copayment per visit (no referral needed if using network provider)	100% after \$15 copayment per visit	Not covered
HEARING AIDS	Not covered	Not covered	Not covered	Not covered

¹ NJ DIRECT15 out-of-network 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	OUT-OF-NETWORK ¹
SPECIALTY AND OUTPATIENT CARE				
SPECIALIST OFFICE VISITS	100% after \$15 copayment per visit; PCP referral required	100% after \$15 copayment per visit; PCP referral required	100% after \$15 copayment per visit	70% after deductible; no coverage for wellness care
ALLERGY TESTING	100% after \$15 copayment per visit	100% after \$15 copayment per visit	100% after \$15 copayment per visit	70% after deductible
ALLERGY TREATMENT ROUTINE INJECTIONS	100% after \$15 copayment per visit	100% after \$15 copayment per visit	100% after \$15 copayment per visit	70% after deductible
PRENATAL CARE/ MATERNITY CARE	\$15 copayment for first prenatal office visit then 100% covered. Beginning Right Maternity Program - a voluntary prenatal education program	\$15 copayment for first prenatal office visit then 100% covered. Healthy Babies - a voluntary prenatal education program	\$15 copayment for first prenatal office visit then 100% covered. Precious Additions - a voluntary prenatal education program	70% after deductible
INFERTILITY SERVICES (MUST BE PRE-CERTIFIED)	Diagnosis covered after \$15 copayment; treatment covered with limitations after \$15 copayment	Diagnosis covered after \$15 copayment; treatment covered with limitations after \$15 copayment	Diagnosis covered after \$15 copayment; treatment covered with limitations after \$15 copayment	Diagnosis covered at 70% after deductible; treatment covered with limitations at 70% after deductible
OUTPATIENT FACILITY VISITS				
CHEMOTHERAPY	100%; no copayment	100%; no copayment	100%; no copayment	70% after deductible
RADIATION THERAPY	100%; no copayment	100%; no copayment	100%; no copayment	70% after deductible
INFUSION THERAPY	100% after \$15 copayment per visit	100% after \$15 copayment per visit	100% after \$15 copayment per visit	70% after deductible
X-RAYS AND LAB TESTS (OUTPATIENT)	100%; no copayment	100%; no copayment	100%; no copayment	70% after deductible
OUTPATIENT THERAPY (SPEECH,² OCCUPATIONAL, PHYSICAL)	100%; after \$15 copayment per visit; limit of 60 visits per condition per calendar year	100%; after \$15 copayment per visit; limit of 60 visits per condition per calendar year	100% after \$15 copayment per visit	70% after deductible

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² 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	OUT-OF-NETWORK ¹
SPECIALTY AND OUTPATIENT CARE				
OUTPATIENT CARDIAC REHABILITATION THERAPY	100% after \$15 copayment per visit	100% after \$15 copayment per visit	100% after \$15 copayment per visit	70% after deductible
CHIROPRACTIC CARE	100%; after \$15 copayment per visit; limit of 20 visits per calendar year; PCP referral required	100%; after \$15 copayment per visit; limit of 20 visits per calendar year	100% after \$15 copayment per visit; limit of 30 visits per calendar year combined in-network and out-of-network	70% after deductible for up to 30 visits per calendar year combined in-network and out-of-network
HOME HEALTH CARE	Services and supplies covered at 100% with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered	Services and supplies covered at 100% with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered	Services and supplies covered at 100% with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered	Services and supplies covered at 70% after deductible with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered
HOSPICE CARE (OUTPATIENT)	100%; no copayment	100%; no copayment	100%; no copayment	70% after deductible
DURABLE MEDICAL EQUIPMENT (DME)	\$100 deductible; then 100% for rest of calendar year	\$100 deductible; then 100% for rest of calendar year	90%; no copayment	70% after deductible
PROSTHETIC DEVICES (MUST BE APPROVED IN ADVANCE)	\$100 deductible; then 100% for rest of calendar year; combined deductible with Durable Medical Equipment	\$100 deductible; then 100% for rest of calendar year; combined deductible with Durable Medical Equipment	90%; no copayment	70% after deductible
INPATIENT SERVICES				
HOSPITAL (ROOM AND BOARD AND OTHER INPATIENT SERVICES)	100%; no copayment	100%; no copayment	100%; no copayment	70% after separate \$200 deductible per hospital stay
SKILLED NURSING FACILITIES	100%; no copayment; for up to 120 days per calendar year	100%; no copayment; for up to 120 days per calendar year	100%; no copayment; for up to 120 days per calendar year; combined in-network and out-of-network	70% after deductible; for up to 60 days per calendar year; combined in-network and out-of-network
HOSPICE FACILITY	100%; no copayment	100%; no copayment	100%; no copayment	70% after deductible
INPATIENT VISITS	100%; no copayment	100%; no copayment	100%; no copayment	70% after deductible

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			IN-NETWORK	OUT-OF-NETWORK ¹
SURGERY AND ANESTHESIA				
INPATIENT SURGERY	100%; no copayment	100%; no copayment	100%; no copayment	70% after deductible
OUTPATIENT SURGERY	100%; no copayment	100%; no copayment	100%; no copayment	70% after deductible
MENTAL HEALTH				
INPATIENT TREATMENT³	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%	50 days per calendar year at 50% after deductible
OUTPATIENT TREATMENT³	100% after \$15 copayment per visit; up to 30 visits per calendar year	100% after \$15 copayment per visit; up to 30 visits per calendar year	90%	70% after deductible
ALCOHOL AND DRUG ABUSE				
INPATIENT TREATMENT	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
INPATIENT DETOXIFICATION	100%; no copayment	100%; no copayment	Same as any other illness	Same as any other illness
OUTPATIENT TREATMENT	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	70% after deductible
INPATIENT REHABILITATION	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
OUTPATIENT DETOXIFICATION	100%; no copayment	100%; no copayment	Same as any other illness	Same as any other illness

¹ NJ DIRECT15 out-of-network 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.

³ Biologically-based mental health conditions are treated like any other illness and are not subject to separate mental health visit limits.

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			IN-NETWORK	OUT-OF-NETWORK ¹
EMERGENCY CARE				
HOSPITAL EMERGENCY ROOM (COPAYMENT WAIVED IF ADMITTED)	100% after \$50 copayment	100% after \$50 copayment	100% after \$50 copayment	100% after \$50 copayment
AMBULANCE (FOR EMERGENCY TRANSPORTATION ONLY)	100%; no copayment	100%; no copayment	90%; no copayment	70% after deductible
VOLUNTARY PROGRAMS				
DISEASE MANAGEMENT PROGRAMS⁴	Asthma, Chronic Heart Failure, Chronic Hepatitis, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Chron's Disease, Coronary Artery Disease, Diabetes, Gastro Esophageal Reflux, Inflammatory Bowel Disease, Low Back Pain, and Weight Management	Asthma, Chronic Obstructive Pulmonary Disease, Diabetes, Heart Disease, Hepatitis C, Inflammatory Bowel Disease, Low Back Pain, Osteoarthritis, Osteoporosis, and Weight Complications	Asthma, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Diabetes, Heart Failure, Hepatitis C, Obesity, and Multiple Sclerosis	Asthma, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Diabetes, Heart Failure, Hepatitis C, Obesity, and Multiple Sclerosis
PLAN DEDUCTIBLES, OUT-OF-POCKET MAXIMUMS, AND ANNUAL/LIFETIME BENEFIT MAXIMUMS				
DEDUCTIBLES (INDIVIDUAL)	None	None	None	\$100 per calendar year; \$200 per hospital admission
DEDUCTIBLES (FAMILY MAXIMUM)	None	None	None	\$250 per family, per calendar year; \$200 per hospital admission
MAXIMUM OUT-OF-POCKET (INDIVIDUAL)	No maximum	No maximum	\$400 per calendar year (coinsurance only)	\$2,000 per calendar year (coinsurance only)
MAXIMUM OUT-OF-POCKET (FAMILY)	No maximum	No maximum	\$1,000 per calendar year (coinsurance only)	\$5,000 per calendar year (coinsurance only)
MAXIMUM PLAN COVERED EXPENSES ANNUAL/LIFETIME	Unlimited	Unlimited	Unlimited	Unlimited

¹ NJ DIRECT15 out-of-network 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.

⁴ 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.

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PRESCRIPTION DRUG COVERAGE FOR STATE EMPLOYEES

State Employees are eligible to enroll in the **Employee Prescription Drug Plan** as a separate prescription drug benefit. The Employee Prescription Drug Plan has a three-tier copayment design. For each 30-day supply when purchased at a retail pharmacy the copayment is \$3 for generic drugs (first tier); \$10 for brand name prescription drugs without generic equivalents (second tier); and \$25 for brand name drugs where a generic equivalent is available (third tier).

Mail order prescription drug copayments for up to a 90-day supply are \$5 for generic drugs (first tier); \$15 for brand name drugs without generic equivalents (second tier); and \$40 for brand name drugs where a generic equivalent is available.

For more information see the *Employee Prescription Drug Plan Member Handbook* which is available from your human resources representative, from the Division of Pensions and Benefits, or on our Web site at: www.state.nj.us/treasury/pensions/

DENTAL COVERAGE FOR STATE EMPLOYEES

State Employees are eligible to enroll for dental coverage in the **Employee Dental Plans**, which offer two basic types of plan: the Dental Expense Plan, and a selection of Dental Plan Organizations (DPOs). For more information, see the *Employee Dental Plans Member Handbook* which is available from the Division of Pensions and Benefits on our Web site at: www.state.nj.us/treasury/pensions/

CONTINUED COVERAGE FOR CHILDREN AGE 26 THROUGH 31

Coverage for an enrolled child ends on December 31 of the year in which the child turns age 26. When a covered child turns age 26, you will receive a COBRA notice outlining the right to purchase continued health coverage for up to 36 months. However, under the provisions of Chapter 375, P.L. 2005, a child who is under age 31, may be eligible for continued medical and prescription drug coverage at a lesser cost than COBRA. See Fact Sheet #74, *Health Benefits Coverage of Children Until Age 31*. Continued dental and vision coverage may be available under COBRA.

If a covered child is not capable of self-support when he or she reaches age 26 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuance of coverage. A *Continuance for Dependent with Disabilities* form and proof of the child's condition must be submitted no more than 31 days after the date that coverage would end. Since coverage ends on December 31 of the year the child turns 26, you usually have until January 31 to file the form. See Fact Sheet #51, *Continuing Health Benefits Coverage for Over Age Children with Disabilities*.

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