



## STATE ACTIVE GROUP MEDICAL PLAN DESIGN - PLAN YEAR 2026

### Explore Your Benefits

Side-by-Side Medical Comparison	Aetna Freedom/ Freedom 2019*	Horizon NJ DIRECT/ NJ DIRECT 2019*	Aetna Freedom15	Horizon NJ DIRECT15	Aetna Freedom1525	Horizon NJ DIRECT1525
Primary Care Copayment	\$15	\$15	\$15	\$15	\$15	\$15
Specialist Care Copayment	\$30	\$30	\$15	\$15	\$25	\$25
Emergency Room Copayment	\$150 <sup>1</sup>	\$150 <sup>1</sup>	\$100	\$100	\$100	\$100
In-Network Deductible	\$100 <sup>2</sup> (if hired after 7/1/19)	\$100 <sup>2</sup> (if hired after 7/1/19)	None	None	None	None
In-Network Coinsurance	10% <sup>3</sup>	10% <sup>3</sup>	10% <sup>3</sup>	10% <sup>3</sup>	10% <sup>3</sup>	10% <sup>3</sup>
In-Network Coinsurance Maximum (Individual/Family)	\$800/\$2,000	\$800/\$2,000	\$400/\$1,000	\$400/\$1,000	\$400/\$1,000	\$400/\$1,000
In-Network Out-of-Pocket Maximum (Individual/Family)	\$8,480/\$16,960	\$8,480/\$16,960	\$8,480/\$16,960	\$8,480/\$16,960	\$8,480/\$16,960	\$8,480/\$16,960
Out-of-Network Deductible (Individual/Family)	\$400/\$1,000	\$400/\$1,000	\$100/\$250	\$100/\$250	\$100/\$250	\$100/\$250
Out-of-Network Coinsurance <sup>4</sup>	30%	30%	30%	30%	30%	30%
Out-of-Network Out-of-Pocket Maximum (Individual/Family) <sup>5</sup>	\$2,000/\$5,000	\$2,000/\$5,000	\$2,000/\$5,000	\$2,000/\$5,000	\$2,000/\$5,000	\$2,000/\$5,000
Out-of-Network Inpatient Hospital Deductible	\$500/stay	\$500/stay	\$200/stay	\$200/stay	\$200/stay	\$200/stay



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Side-by-Side Medical Comparison	Aetna Freedom2030	Horizon NJ DIRECT2030	Aetna Freedom2035	Horizon NJ DIRECT2035	Aetna HMO	Horizon HMO <sup>6</sup>
Primary Care Copayment	\$20	\$20	\$20	\$20	\$15	\$15
Specialist Care Copayment	\$30 adult/ \$20 child**	\$30 adult/ \$20 child**	\$35	\$35	\$30	\$30
Emergency Room Copayment	\$125	\$125	\$300	\$300	\$100	\$100
In-Network Deductible	None	None	\$200/\$500 <sup>7</sup>	\$200/\$500 <sup>7</sup>	\$100 per individual for Durable Medical Equipment	\$100 per individual for Durable Medical Equipment
In-Network Coinsurance	10% <sup>3</sup>	10% <sup>3</sup>	20% after deductible	20% after deductible	None	None
In-Network Coinsurance Maximum (Individual/Family)	\$800/\$2,000	\$800/\$2,000	\$2,000/\$5,000	\$2,000/\$5,000	None	None
In-Network Out-of-Pocket Maximum (Individual/Family)	\$8,480/\$16,960	\$8,480/\$16,960	\$8,480/\$16,960	\$8,480/\$16,960	\$8,480/\$16,960	\$8,480/\$16,960
Out-of-Network Deductible (Individual/Family)	\$200/\$500	\$200/\$500	\$800/\$2,000	\$800/\$2,000		
Out-of-Network Coinsurance <sup>4</sup>	30%	30%	40%	40%		
Out-of-Network Out-of-Pocket Maximum (Individual/Family) <sup>5</sup>	\$5,000/\$12,500	\$5,000/\$12,500	\$6,500/\$13,000	\$6,500/\$13,000		
Out-of-Network Inpatient Hospital Deductible	\$500/stay	\$500/stay	\$600/stay	\$600/stay		



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Side-by-Side Medical Comparison	Aetna Liberty Plus		Horizon OMNIA		Aetna Freedom HDHigh***	Horizon NJ DIRECT HDHigh***	Aetna Freedom HDLow***	Horizon NJ DIRECT HDLow***
	TIER 1	TIER 2	TIER 1	TIER 2				
Primary Care Copayment	\$5	\$20	\$5	\$20	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Specialist Care Copayment	\$20	\$35	\$20	\$35	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Emergency Room Copayment	\$100	\$100	\$100	\$100	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
In-Network Deductible	None	\$1,500 <sup>8</sup>	None	\$1,500 <sup>8</sup>	\$4,200 <sup>8</sup>	\$4,200 <sup>8</sup>	\$1,700 <sup>8</sup>	\$1,700 <sup>8</sup>
In-Network Coinsurance	None	20%	None	20%	20% after deductible	20% after deductible	20% after deductible	20% after deductible
In-Network Coinsurance Maximum (Individual/Family)	None	None	None	None	\$1,000/\$2,000	\$1,000/\$2,000	\$1,000/\$2,000	\$1,000/\$2,000
In-Network Out-of-Pocket Maximum (Individual/Family)	\$2,500 <sup>8</sup>	\$4,500 <sup>8</sup>	\$2,500 <sup>8</sup>	\$4,500 <sup>8</sup>	\$5,200/\$10,400	\$5,200/\$10,400	\$2,700/\$5,400	\$2,700/\$5,400
Out-of-Network Deductible (Individual/Family)					See In-Network Deductible <sup>9</sup>	See In-Network Deductible <sup>9</sup>	See In-Network Deductible <sup>9</sup>	See In-Network Deductible <sup>9</sup>
Out-of-Network Coinsurance <sup>4</sup>					40%	40%	40%	40%
Out-of-Network Out-of-Pocket Maximum (Individual/Family) <sup>5</sup>					\$6,200/\$12,400	\$6,200/\$12,400	\$3,700/\$7,400	\$3,700/\$7,400
Out-of-Network Inpatient Hospital Deductible					None	None	None	None

\* Members hired before July 1, 2019, will be enrolled in Aetna Freedom or Horizon NJ DIRECT. Members hired after July 1, 2019, will be enrolled in Aetna Freedom 2019 or Horizon NJ DIRECT 2019.

\*\* Age 26 and under.

\*\*\*HD = High Deductible Health Plan.

<sup>1</sup> \$50 for adults referred to the emergency room by their primary care physician or for children (through age 19) referred by their pediatrician.

<sup>2</sup> \$100 in-network deductible has exclusions: 2nd wellness visit, preventive, obstetrics, pediatrics, and any deductible applied to other services.

<sup>3</sup> On select services.

<sup>4</sup> After deductible.

<sup>5</sup> All plans with out-of-network benefits have specified dollar limits for chiropractic, physical therapy, and acupuncture.

<sup>6</sup> Service area for Horizon HMO plans are limited to New Jersey, New Castle County in Delaware, and bordering counties of Pennsylvania and New York.

<sup>7</sup> Applies to services that don't require a copayment.

<sup>8</sup> Family amounts are 2x member amounts listed in table.

<sup>9</sup> Out-of-network deductible is combined with in-network deductible.

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