NJDPB Pensions & Benefits

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LOCAL GOVERNMENT ACTIVE GROUP
MEDICAL PLAN DESIGN - PLAN YEAR 2026

HA-0896-1125

Side-by-Side Medical Comparison	Aetna Freedom/ Freedom 2019*	Horizon NJ DIRECT/ NJ DIRECT 2019*	Aetna Freedom10	Horizon NJ DIRECT10	Aetna Freedom15	Horizon NJ DIRECT15
Primary Care Copayment	$15	$15	$10	$10	$15	$15
Specialist Care Copayment	$15	$15	$10	$10	$15	$15
Emergency Room Copayment	$150[1]	$150[1]	$75	$75	$100	$100
In-Network Deductible	$100[2] (if hired after 7/1/19)	$100[2] (if hired after 7/1/19)	None	None	None	None
In-Network Coinsurance	10%[3]	10%[3]	10%[3]	10%[3]	10%[3]	10%[3]
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	$400/$1,000	$400/$1,000	$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[4]	30%	30%	20%	20%	30%	30%
Out-of-Network Out-of-Pocket Maximum (Individual/Family)[5]	$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	$500	$200/stay	$200/stay	$200/stay	$200/stay

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Side-by-Side Medical Comparison	Aetna Freedom1525	Horizon NJ DIRECT1525	Aetna Freedom2030	Horizon NJ DIRECT2030	Aetna Freedom2035	Horizon NJ DIRECT2035
Primary Care Copayment	$15	$15	$20	$20	$20	$20
Specialist Care Copayment	$25	$25	$30 adult/ $20 child**	$30 adult/ $20 child**	$35	$35
Emergency Room Copayment	$100	$100	$125	$125	$300	$300
In-Network Deductible	None	None	None	None	$200/$500[6]	$200/$500[6]
In-Network Coinsurance	10%[3]	10%[3]	10%[3]	10%[3]	20% after deductible	20% after deductible
In-Network Coinsurance Maximum (Individual/Family)	$400/$1,000	$400/$1,000	$800/$2,000	$800/$2,000	$2,000/$5,000	$2,000/$5,000
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)	$100/$250	$100/$250	$200/$500	$200/$500	$800/$2,000	$800/$2,000
Out-of-Network Coinsurance[4]	30%	30%	30%	30%	40%	40%
Out-of-Network Out-of-Pocket Maximum (Individual/Family)[5]	$2,000/$5,000	$2,000/$5,000	$5,000/$12,500	$5,000/$12,500	$6,500/$13,000	$6,500/$13,000
Out-of-Network Inpatient Hospital Deductible	$200/stay	$200/stay	$500/stay	$500/stay	$600/stay	$600/stay

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Side-by-Side Medical Comparison	Aetna HMO	Horizon HMO[7]	Aetna Liberty Plus		Horizon OMNIA		Aetna Freedom HDHigh***	Horizon NJ DIRECT HDHigh***
			TIER 1	TIER 2	TIER 1	TIER 2		
Primary Care Copayment	$10	$10	$5	$20	$5	$20	20% coinsurance after deductible	20% coinsurance after deductible
Specialist Care Copayment	$10	$10	$15	$30	$15	$30	20% coinsurance after deductible	20% coinsurance after deductible
Emergency Room Copayment	$85	$85	$100	$100	$100	$100	20% coinsurance after deductible	20% coinsurance after deductible
In-Network Deductible	$100 per individual for Durable Medical Equipmentt	$100 per individual for Durable Medical Equipment	None	$1,500[8]	None	$1,500[8]	$4,200[8]	$4,200[8]
In-Network Coinsurance	None	None	None	20%	None	20%	20% after deductible	20% after deductible
In-Network Coinsurance Maximum (Individual/Family)	None	None	None	None	None	None	$1,000/$2,000	$1,000/$2,000
In-Network Out-of-Pocket Maximum (Individual/Family)	$8,480/$16,960	$8,480/$16,960	$2,500[8]	$4,500[8]	$2,500[8]	$4,500[8]	$5,200/$10,400	$5,200/$10,400
Out-of-Network Deductible (Individual/Family)							See In-Network Deductible[9]	See In-Network Deductible[9]
Out-of-Network Coinsurance[4]							40%	40%
Out-of-Network Out-of-Pocket Maximum (Individual/Family)[5]							$6,200/$12,400	$6,200/$12,400
Out-of-Network Inpatient Hospital Deductible								

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Side-by-Side Medical Comparison	Aetna Freedom HDLow***	Horizon NJ DIRECT HDLow***
Primary Care Copayment	20% coinsurance after deductible	20% coinsurance after deductible
Specialist Care Copayment	20% coinsurance after deductible	20% coinsurance after deductible
Emergency Room Copayment	20% coinsurance after deductible	20% coinsurance after deductible
In-Network Deductible	$1,700[8]	$1,700[8]
In-Network Coinsurance	20% after deductible	20% after deductible
In-Network Coinsurance Maximum (Individual/Family)	$1,000/$2,000	$1,000/$2,000
In-Network Out-of-Pocket Maximum (Individual/Family)	$2,700/$5,400	$2,700/$5,400
Out-of-Network Deductible (Individual/Family)	See In-Network Deductible[9]	See In-Network Deductible[9]
Out-of-Network Coinsurance[4]	40%	40%
Out-of-Network Out-of-Pocket Maximum (Individual/Family)[5]	$3,700/$7,400	$3,700/$7,400
Out-of-Network Inpatient Hospital Deductible		

* **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 Plan**

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

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

3 On select services.

4 After deductible.

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

6 Applies to services that do not require a copayment.

7 Services for Horizon HMO plans are limited to New Jersey, New Castle County in Delaware, and bordering counties of Pennsylvania and New York.

8 Family amounts are 2x member amounts listed in table.

9 Out-of-network deductible is combined with in-network deductible.

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