



Explore Your Benefits

UNION NEGOTIATED AND NON-ALIGNED PLANS MEDICAL PLAN DESIGN - PLAN YEAR 2026 STATE ACTIVE GROUP

Side-by-Side Medical Comparison	Aetna Freedom/ Freedom 2019*	Horizon NJ DIRECT/ NJ DIRECT 2019*	Aetna HMO	Horizon HMO ¹	Aetna Liberty Plus		Horizon OMNIA	
					TIER 1	TIER 2	TIER 1	TIER 2
Primary Care Copayment	\$15	\$15	\$15	\$15	\$5	\$20	\$5	\$20
Specialist Care Copayment	\$30	\$30	\$30	\$30	\$20	\$35	\$20	\$35
Emergency Room Copayment	\$150 ²	\$150 ²	\$100	\$100	\$100	\$100	\$100	\$100
In-Network Deductible	\$100 ³ (if hired after 7/1/19)	\$100 ³ (if hired after 7/1/19)	\$100 per individual for Durable Medical Equipment	\$100 per individual for Durable Medical Equipment	None	\$1,500 ⁴	None	\$1,500 ⁴
In-Network Coinsurance	10% ⁵	10% ⁵	None	None	None	20%	None	20%
In-Network Coinsurance Maximum (Individual/Family)	\$800/\$2,000	\$800/\$2,000	None	None	None	None	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	\$2,500 ⁴	\$4,500 ⁴	\$2,500 ⁴	\$4,500 ⁴
Out-of-Network Deductible (Individual/Family)	\$400/\$1,000	\$400/\$1,000						
Out-of-Network Coinsurance ⁶	30%	30%						
Out-of-Network Out-of-Pocket Maximum (Individual/Family) ⁷	\$2,000/\$5,000	\$2,000/\$5,000						
Out-of-Network Inpatient Hospital Deductible	\$500/stay	\$500/stay						



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Side-by-Side Medical Comparison	Aetna Freedom HDHigh**	Horizon NJ DIRECT HDHigh**	Aetna Freedom HDLow**	Horizon NJ DIRECT HDLow**
Primary Care Copayment	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Specialist Care Copayment	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Emergency Room Copayment	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
In-Network Deductible	\$4,200 ⁴	\$4,200 ⁴	\$1,700 ⁴	\$1,700 ⁴
In-Network Coinsurance	20% after deductible	20% after deductible	20% after deductible	20% after deductible
In-Network Coinsurance Maximum (Individual/Family)	\$1,000/\$2,000	\$1,000/\$2,000	\$1,000/\$2,000	\$1,000/\$2,000
In-Network Out-of-Pocket Maximum (Individual/Family)	\$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 ⁸	See In-Network Deductible ⁸	See In-Network Deductible ⁸	See In-Network Deductible ⁸
Out-of-Network Coinsurance ⁶	40%	40%	40%	40%
Out-of-Network Out-of-Pocket Maximum (Individual/Family) ⁷	\$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

Note: Aetna CWA Unity Freedom and Horizon CWA Unity DIRECT members and spouses who participate in NJWELL and complete the necessary health screenings and activities can earn a financial reward of \$350 each.

* **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 Unity Freedom 2019 or Horizon NJ DIRECT 2019.**

** **HD = High Deductible Health Plan**

¹ Service areas for Horizon HMO plans are limited to New Jersey, New Castle County in Delaware, and bordering counties of Pennsylvania and New York.

² \$50 for adults referred to the emergency room by their primary care physician or for children (through age 19) referred by their pediatrician.

³ \$100 in-network deductible has exclusions: 2nd wellness visit, preventive, obstetrics, pediatrics, and any deductible applied to other services.

⁴ Family amounts are 2x member amounts listed in table.

⁵ On select services.

⁶ After deductible.

⁷ All plans with out-of-network benefits have specified dollar limits for chiropractic, physical therapy, and acupuncture.

⁸ Out-of-network deductible is combined with in-network deductible.

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