NJDPB Pensions & Benefits

Explore Your Benefits

STATE ACTIVE GROUP
MEDICAL PLAN DESIGN - PLAN YEAR 2027

HA-0895-1026

Side-by-Side Medical Comparison	26 Aetna Freedom	26 Horizon NJ DIRECT	26 Aetna Freedom 15	26 Horizon NJ DIRECT 15	26 Aetna Freedom 1525	26 Horizon NJ DIRECT 1525
Primary Care Copayment	$15	$15	$15	$15	$15	$15
Specialist Care Copayment	$30	$30	$15	$15	$25	$25
Emergency Room Copayment	$150 [1]	$150 [1]	$100	$100	$100	$100
In-Network Ambulatory Surgical Center for Ambulatory Surgical Center-Covered Procedure	0% coinsurance [4]	0% coinsurance [4]	0% coinsurance [4]	0% coinsurance [4]	0% coinsurance [4]	0% coinsurance [4]
In-Network Deductible	$110 (individual)/ $220 (family) [2]	$110 (individual)/ $220 (family)[2]	$110 (individual)/ $220 (family) [2]	$110 (individual)/ $220 (family) [2]	$110 (individual)/ $220 (family) [2]	$110 (individual)/ $220 (family) [2]
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)	$9,880/$19,760	$9,880/$19,760	$9,880/$19,760	$9,880/$19,760	$9,880/$19,760	$9,880/$19,760
Out-of-Network Deductible (Individual/Family)	$750/$1,500	$750/$1,500	$750/$1,500	$750/$1,500	$750/$1,500	$750/$1,500
Out-of-Network Coinsurance	30% [4]	30% [4]	30% [4]	30% [4]	30% [4]	30% [4]
Out-of-Network Out-of-Pocket Maximum (Individual/Family)	$2,500/$6,000 [5]	$2,500/$6,000 [5]	$2,500/$6,000 [5]	$2,500/$6,000 [5]	$2,500/$6,000 [5]	$2,500/$6,000 [5]
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	26 Aetna Freedom 2030	26 Horizon NJ DIRECT 2030	26 Aetna Freedom 2035	26 Horizon NJ DIRECT 2035	26 Aetna HMO	26 Horizon HMO [6]
Primary Care Copayment	$20	$20	$20	$20	$15	$15
Specialist Care Copayment	$30 adult/ $20 child (26 and under)	$30 adult/ $20 child (26 and under)	$35	$35	$30	$30
Emergency Room Copayment	$125	$125	$300	$300	$100	$100
In-Network Ambulatory Surgical Center for Ambulatory Surgical Center-Covered Procedure	0% coinsurance [4]	0% coinsurance [4]	20% coinsurance [4]	20% coinsurance [4]		
In-Network Deductible	$110 (individual)/ $220 (family) [2]	$110 (individual)/ $220 (family) [2]	$200/$500 [7]	$200/$500 [7]	$100 per individual for Durable Medical Equipment	$100 per individual for Durable Medical Equipment
In-Network Coinsurance	10% [3]	10% [3]	20% [4]	20% [4]	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)	$9,880/$19,760	$9,880/$19,760	$9,880/$19,760	$9,880/$19,760	$9,880/$19,760	$9,880/$19,760
Out-of-Network Deductible (Individual/Family)	$750/$1,500	$750/$1,500	$800/$2,000	$800/$2,000		
Out-of-Network Coinsurance	30% [4]	30% [4]	40% [4]	40% [4]		
Out-of-Network Out-of-Pocket Maximum (Individual/Family)	$5,000/$12,500 [5]	$5,000/$12,500 [5]	$6,500/$13,000 [5]	$6,500/$13,000 [5]		
Out-of-Network Inpatient Hospital Deductible	$500/stay	$500/stay	$600/stay	$600/stay		

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Side-by-Side Medical Comparison	26 Aetna Liberty Plus		26 Horizon OMNIA		26 Aetna Freedom HDHigh*	26 Horizon NJ DIRECT HDHigh*	26 Aetna Freedom HDLow*	26 Horizon NJ DIRECT HDLow*
	TIER 1	TIER 2	TIER 1	TIER 2				
Primary Care Copayment	$5	$20	$5	$20	20% coinsurance [4]	20% coinsurance [4]	20% coinsurance [4]	20% coinsurance [4]
Specialist Care Copayment	$20	$35	$20	$35	20% coinsurance [4]	20% coinsurance [4]	20% coinsurance [4]	20% coinsurance [4]
Emergency Room Copayment	$100	$100	$100	$100	20% coinsurance [4]	20% coinsurance [4]	20% coinsurance [4]	20% coinsurance [4]
In-Network Ambulatory Surgical Center for Ambulatory Surgical Center-Covered Procedure	$150 copayment	20% coinsurance [4]	$150 copayment	20% coinsurance [4]	20% coinsurance [4]	20% coinsurance [4]	20% coinsurance [4]	20% coinsurance [4]
In-Network Deductible	None	$1,500 [8]	None	$1,500 [8]	$4,250 [8]	$4,250 [8]	$1,750 [8]	$1,750 [8]
In-Network Coinsurance	None	20%	None	20%	20% [4]	20% [4]	20% [4]	20% [4]
In-Network Coinsurance Maximum (Individual/Family)	None	None	None	None	None	None	None	None
In-Network Out-of-Pocket Maximum (Individual/Family)	$2,500 [8]	$4,500 [8]	$2,500 [8]	$4,500 [8]	$5,250/$10,500	$5,250/$10,500	$2,750/$5,500	$2,750/$5,500
Out-of-Network Deductible (Individual/Family)					See In-Network Deductible [9]	See In-Network Deductible [9]	See In-Network Deductible [9]	See In-Network Deductible [9]
Out-of-Network Coinsurance					40% [4]	40% [4]	40% [4]	40% [4]
Out-of-Network Out-of-Pocket Maximum (Individual/Family)					$6,250/$12,500 [5]	$6,250/$12,500 [5]	$3,750/$7,500 [5]	$3,750/$7,500 [5]
Out-of-Network Inpatient Hospital Deductible					None	None	None	None

Note: The copayment for in-network diagnostic imaging is $50 per visit except for preventative and pregnancy-related imaging for all plans excluding the HMO, Tiered Network, and High Deductible Plans.

* **HD = High Deductible Health 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 $110/$220 in-network deductible is applicable to all services except for preventative care and services subject to copayments.
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 Service area for Horizon HMO plans are limited to New Jersey, New Castle County in Delaware, and bordering counties of Pennsylvania and New York.
7 Applies to services that don't require a copayment.
8 Family amounts are 2x member amounts listed in table.
9 Out-of-network deductible is combined with in-network deductible. For HD plans, deductible amounts count only towards the out-of-pocket maximum of the network where services were received.

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