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LOCAL GOVERNMENT ACTIVE GROUP MEDICAL PLAN DESIGN - PLAN YEAR 2027 AETNA AND HORIZON PLANS

Side-by-Side Medical Comparison	Aetna Freedom/ Freedom 2019*	Horizon NJ DIRECT/ NJ DIRECT 2019*	Aetna Freedom 10	Horizon NJ DIRECT 10	Aetna Freedom 15	Horizon NJ DIRECT 15
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)	$9,600/$19,200	$9,600/$19,200	$400/$1,000	$400/$1,000	$9,600/$19,200	$9,600/$19,200
Out-of-Network Deductible (Individual/Family)	$400/$1,000	$400/$1,000	$100/$250	$100/$250	$100/$250	$100/$250
Out-of-Network Coinsurance	30% [4]	30% [4]	20% [4]	20% [4]	30% [4]	30% [4]
Out-of-Network Out-of-Pocket Maximum (Individual/Family)	$2,000/$5,000 [5]	$2,000/$5,000 [5]	$2,000/$5,000 [5]	$2,000/$5,000 [5]	$2,000/$5,000 [5]	$2,000/$5,000 [5]
Out-of-Network Inpatient Hospital Deductible	$500	$500	$200/stay	$200/stay	$200/stay	$200/stay

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LOCAL GOVERNMENT ACTIVE GROUP MEDICAL PLAN DESIGN - PLAN YEAR 2027 AETNA AND HORIZON PLANS

Side-by-Side Medical Comparison	Aetna Freedom 1525	Horizon NJ DIRECT 1525	Aetna Freedom 2030	Horizon NJ DIRECT 2030	Aetna Freedom 2035	Horizon NJ DIRECT 2035
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% [4]	20% [4]
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)	$9,600/$19,200	$9,600/$19,200	$9,600/$19,200	$9,600/$19,200	$9,600/$19,200	$9,600/$19,200
Out-of-Network Deductible (Individual/Family)	$100/$250	$100/$250	$200/$500	$200/$500	$800/$2,000	$800/$2,000
Out-of-Network Coinsurance	30% [4]	30% [4]	30% [4]	30% [4]	40% [4]	40% [4]
Out-of-Network Out-of-Pocket Maximum (Individual/Family)	$2,000/$5,000 [5]	$2,000/$5,000 [5]	$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	$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 [4]	20% coinsurance [4]
Specialist Care Copayment	$10	$10	$15	$30	$15	$30	20% coinsurance [4]	20% coinsurance [4]
Emergency Room Copayment	$85	$85	$100	$100	$100	$100	20% coinsurance [4]	20% coinsurance [4]
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]	$4,250 [8]	$4,250 [8]
In-Network Coinsurance	None	None	None	20%	None	20%	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)	$9,600/$19,200	$9,600/$19,200	$2,500 [8]	$4,500 [8]	$2,500 [8]	$4,500 [8]	$5,250/$10,500	$5,250/$10,500
Out-of-Network Deductible (Individual/Family)							See In-Network Deductible [9]	See In-Network Deductible [9]
Out-of-Network Coinsurance							40% [4]	40% [4]
Out-of-Network Out-of-Pocket Maximum (Individual/Family)							$6,250/$12,500 [5]	$6,250/$12,500 [5]
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 [4]	20% coinsurance [4]
Specialist Care Copayment	20% coinsurance [4]	20% coinsurance [4]
Emergency Room Copayment	20% coinsurance [4]	20% coinsurance [4]
In-Network Deductible	$1,750 [8]	$1,750 [8]
In-Network Coinsurance	20% [4]	20% [4]
In-Network Coinsurance Maximum (Individual/Family)	None	None
In-Network Out-of-Pocket Maximum (Individual/Family)	$2,750/$5,500	$2,750/$5,500
Out-of-Network Deductible (Individual/Family)	See In-Network Deductible [9]	See In-Network Deductible [9]
Out-of-Network Coinsurance	40% [4]	40% [4]
Out-of-Network Out-of-Pocket Maximum (Individual/Family)	$3,750/$7,500 [5]	$3,750/$7,500 [5]
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. For HD plans, deductible amounts count only towards the out-of-pocket maximum of the network where services were received.

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LOCAL GOVERNMENT ACTIVE GROUP MEDICAL PLAN DESIGN - PLAN YEAR 2027 26 AETNA PLANS AND 26 HORIZON PLANS

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Side-by-Side Medical Comparison	26 Aetna Freedom	26 Horizon NJ DIRECT	26 Aetna Freedom 10	26 Horizon NJ DIRECT 10	26 Aetna Freedom 15	26 Horizon NJ DIRECT 15
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 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	$400/$1,000	$400/$1,000	$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]	20% [4]	20% [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	$500	$200/stay	$200/stay	$200/stay	$200/stay

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

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Side-by-Side Medical Comparison	26 Aetna HMO	26 Horizon HMO [7]	26 Aetna Liberty Plus		26 Horizon OMNIA		26 Aetna Freedom HDHigh*	26 Horizon NJ DIRECT HDHigh*
			TIER 1	TIER 2	TIER 1	TIER 2		
Primary Care Copayment	$10	$10	$5	$20	$5	$20	20% coinsurance [4]	20% coinsurance [4]
Specialist Care Copayment	$10	$10	$15	$30	$15	$30	20% coinsurance [4]	20% coinsurance [4]
Emergency Room Copayment	$85	$85	$100	$100	$100	$100	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]
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]	$4,250[8]	$4,250[8]
In-Network Coinsurance	None	None	None	20%	None	20%	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)	$9,880/$19,760	$9,880/$19,760	$2,500 [8]	$4,500 [8]	$2,500 [8]	$4,500 [8]	$5,250/$10,500	$5,250/$10,500
Out-of-Network Deductible (Individual/Family)							See In-Network Deductible [9]	See In-Network Deductible [9]
Out-of-Network Coinsurance							40% [4]	40% [4]
Out-of-Network Out-of-Pocket Maximum (Individual/Family)							$6,250/$12,500 [5]	$6,250/$12,500 [5]
Out-of-Network Inpatient Hospital Deductible								

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LOCAL GOVERNMENT ACTIVE GROUP
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26 AETNA PLANS AND 26 HORIZON PLANS

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Side-by-Side Medical Comparison	26 Aetna Freedom HDLow*	26 Horizon NJ DIRECT HDLow*
Primary Care Copayment	20% coinsurance [4]	20% coinsurance [4]
Specialist Care Copayment	20% coinsurance [4]	20% coinsurance [4]
Emergency Room Copayment	20% coinsurance [4]	20% coinsurance [4]
In-Network Deductible	$1,750 [8]	$1,750 [8]
In-Network Coinsurance	20% [4]	20% [4]
In-Network Coinsurance Maximum (Individual/Family)	None	None
In-Network Out-of-Pocket Maximum (Individual/Family)	$2,750/$5,500	$2,750/$5,500
Out-of-Network Deductible (Individual/Family)	See In-Network Deductible [9]	See In-Network Deductible [9]
Out-of-Network Coinsurance	40% [4]	40% [4]
Out-of-Network Out-of-Pocket Maximum (Individual/Family)	$3,750/$7,500 [5]	$3,750/$7,500 [5]
Out-of-Network Inpatient Hospital Deductible		

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 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. For HD plans, deductible amounts count only towards the out-of-pocket maximum of the network where services were received.

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