NJDPB Pensions & Benefits
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CWA MEMBERS
STATE ACTIVE GROUP
MEDICAL PLAN DESIGN - PLAN YEAR 2027

Side-by-Side Medical Comparison	26 Aetna CWA Unity Freedom	26 Horizon CWA Unity DIRECT	26 Aetna HMO	26 Horizon HMO [1]	26 Aetna Liberty Plus		26 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 Ambulatory Surgical Center for Ambulatory Surgical Center-Covered Procedure	0% coinsurance [6,9]	0% coinsurance [6,9]			$150 Copayment	20% Coinsurance [6,9]	$150 Copayment	20% Coinsurance [6,9]
In-Network Deductible	$110 (individual)/ $220 (family) [3]	$110 (individual)/ $220 (family) [3]	$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
In-Network Out-of-Pocket Maximum (Individual/Family)	$9,880/$19,760	$9,880/$19,760	$9,880/$19,760	$9,880/$19,760	$2,500 [4]	$4,500 [4]	$2,500 [4]	$4,500 [4]
Out-of-Network Deductible (Individual/Family)	$750/$1,500	$750/$1,500						
Out-of-Network Coinsurance	30% [6]	30% [6]						
Out-of-Network Out-of-Pocket Maximum (Individual/Family)	$2,500/$6,000 [7]	$2,500/$6,000 [7]						
Out-of-Network Inpatient Hospital Deductible	$500/stay	$500/stay						

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

Note: For 26 Aetna CWA Unity Freedom and 26 Horizon CWA Unity DIRECT plans only: The copayment for in-network diagnostic imaging is $50 per visit except for preventative and pregnancy-related imaging. Members and spouses who participate in NJWELL and complete the necessary health screenings and activities can earn a financial reward of $350 each.

* **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 $110/$220 in-network deductible is applicable to all services except for preventative care and services subject to copayments.

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

9 50% coinsurance after deductible for In-Network Ambulatory Surgical Center-covered procedures provided outside of an In-Network Ambulatory Surgical Center (where applicable). Covered procedures are endoscopies, intraocular lens procedures, introduction/injection of anesthetic agents, injection/drainage/aspiration procedures on the spine and spinal cord, destruction of neurolytic agent procedures on the somatic nerves, introduction/injection of anesthetic agent/hernia surgeries, carpal tunnel surgeries, arthroscopies, knee arthrotomies, lumpectomies, tonsillectomies, and colonoscopies.

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This is a summary and not intended to provide all information. Although every attempt at accuracy is made, it cannot be guaranteed.