

	Liberty Plus Tiered Network		Freedom	
Benefit	Tier 1	Tier 2 – Nationwide	In network	Out of network
Medical network	APCN+ Multi-Tier Open Access Aetna Select SM		Aetna Choice [®] POS II	
Deductible				
Individual	None	\$1,500	None	\$400
Family	None	\$3,000	None	\$1,000
Coinsurance	0%	20%	10%	30%
Maximum out-of-pocket limit				
Individual	\$2,500	\$4,500	\$9,600	\$2,000
Family	\$5,000	\$9,000	\$19,200	\$5,000
Doctors' office visits: primary care physician selection not required				
Primary care office visit	\$5	\$20	\$15	30% after deductible
Specialist office visit	\$15	\$30	\$15	30% after deductible
Diagnostic procedures				
Freestanding lab/radiology/advanced imaging	\$0	\$0	\$0	30% after deductible
Outpatient lab/radiology/advanced imaging	\$15	20% after deductible	\$0	30% after deductible
Hospital care				
Inpatient admission	\$150 per admission	20% after deductible	\$0	\$500/stay plus 30% after deductible
Outpatient department services/surgery	\$150	20% after deductible	\$0	30% after deductible
Emergency care				
Emergency room	\$100	\$100	\$150	\$150
Ambulance	\$0	\$0	10%	30% after deductible
Urgent care	\$15	\$30	\$15	30% after deductible
Other services				
Acupuncture	\$15	20% after deductible	\$15	30% after deductible; lesser of \$60/visit or 75% of INN cost/visit
Short-term therapies: Physical, occupational, speech, respiratory	\$5 office visit/\$15 outpatient facility	\$20 office visit/20% after deductible at outpatient facility	\$15	30% after deductible for speech and occupational therapy; lesser of \$52/visit or 75% of INN cost/visit for physical therapy
PT/OT/SP limits	30-visit maximum each per calendar year		Based on medical necessity	
Chiropractic care	\$15	\$30	\$15	30% after deductible; lesser of \$35/visit or 75% of INN cost/visit
Chiropractic limits	25-visit maximum per calendar year		30-visit maximum per calendar year	
Durable medical equipment	\$0	\$0	10%	30% after deductible
Out-of-network reimbursement	No out-of-network coverage		175% of CMS	

¹Services performed at a hospital when not medically necessary will be covered at 50% after deductible in and out of network

- INN cost = in-network cost
- Retiree plan options are available at [NJ.gov/treasury/pensions/hb-retired-shbp.shtml](https://nj.gov/treasury/pensions/hb-retired-shbp.shtml).
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Freedom 2019		
Benefit	In network	Out of network
Medical network		
Aetna Choice® POS II		
Deductible		
Individual	\$100	\$400
Family	None	\$1,000
Coinsurance	10%	30%
Coinsurance maximum out-of-pocket limit		
Individual	\$800	\$2,000
Family	\$2,000	\$5,000
Maximum out-of-pocket limit		
Individual	\$9,600	\$2,000
Family	\$19,200	\$5,000
Doctors' office visits: primary care physician selection not required		
Primary care office visit	\$15	30% after deductible
Specialist office visit	\$15	30% after deductible
Diagnostic procedures		
Freestanding lab/radiology/advanced imaging	\$0	30% after deductible
Outpatient lab/radiology/advanced imaging	\$0	30% after deductible
Hospital care		
Inpatient admission	\$0	\$500/stay plus 30% after deductible
Outpatient department services/surgery	\$0	30% after deductible
Emergency care		
Emergency room	\$150	\$150
Ambulance	10% after deductible	30% after deductible
Urgent care	\$15	30% after deductible
Other services		
Acupuncture	\$15	30% after deductible; lesser of \$60/visit or 75% of INN cost/visit
Short-term therapies: Physical, occupational, speech, respiratory	\$15	30% after deductible for speech and occupational therapy; lesser of \$52/visit or 75% of INN cost/visit for physical therapy
PT/OT/SP limits	Based on medical necessity	
Chiropractic care	\$15	30% after deductible; lesser of \$35/visit or 75% of INN cost/visit
Chiropractic limits	30-visit maximum per benefits period	
Durable medical equipment	10% after deductible	30% after deductible
Out-of-network reimbursement		
175% of CMS		

• INN cost = in-network cost



	Freedom 10		Freedom 15	
Benefit	In network	Out of network	In network	Out of network
Medical network			Aetna Choice® POS II	
Deductible				
Individual	\$0	\$100	None	\$100
Family	\$0	\$250	None	\$250
Coinsurance	10%	20%	10%	30%
Maximum out-of-pocket limit				
Individual	\$400	\$2,000	\$9,600	\$2,000
Family	\$1,000	\$5,000	\$19,200	\$5,000
Doctors' office visits: primary care physician selection not required				
Primary care office visit	\$10	20% after deductible	\$15	30% after deductible
Specialist office visit	\$10	20% after deductible	\$15	30% after deductible
Diagnostic procedures				
Freestanding lab/radiology/ advanced imaging	\$0	20% after deductible	\$0	30% after deductible
Outpatient lab/radiology/ advanced imaging	\$0	20% after deductible	\$0	30% after deductible
Hospital care				
Inpatient admission	\$0	\$200/stay plus 20% after deductible	\$0	\$200/stay plus 30% after deductible
Outpatient department services/surgery	\$0	20% after deductible	\$0	30% after deductible
Emergency care				
Emergency room	\$75	\$75	\$100	\$100
Ambulance	10%	20% after deductible	10%	30% after deductible
Urgent care	\$10	20% after deductible	\$15	30% after deductible
Other services				
Acupuncture	\$10	20% after deductible; lesser of \$60/visit or 75% of INN cost/visit	\$15	30% after deductible; lesser of \$60/visit or 75% of INN cost/visit
Short-term therapies: Physical, occupational, speech, respiratory	\$10	20% after deductible for speech and occupational therapy; lesser of \$52/ visit or 75% of INN cost/ visit for physical therapy	\$15	30% after deductible for speech and occupational therapy; lesser of \$52/ visit or 75% of INN cost/ visit for physical therapy
PT/OT/SP limits	Based on medical necessity		Based on medical necessity	
Chiropractic care	\$10	20% after deductible; lesser of \$35/visit or 75% of INN cost/visit	\$15	30% after deductible; lesser of \$35/visit or 75% of INN cost/visit
Chiropractic limits	30-visit maximum per calendar year		30-visit maximum per calendar year	
Durable medical equipment	10%	20% after deductible	10%	30% after deductible
Out-of-network reimbursement	90% of FAIR Health national		90% of FAIR Health national	

*Services performed at a hospital when not medically necessary will be covered at 50% after deductible in and out of network

- INN cost = in-network cost
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	Freedom 1525		Freedom 2030	
Benefit	In network	Out of network	In network	Out of network
Medical network	Aetna Choice® POS II		Aetna Choice® POS II	
Deductible				
Individual	None	\$100	None	\$200
Family	None	\$250	None	\$500
Coinsurance	10% ¹	30%	10%	30%
Maximum out-of-pocket limit				
Individual	\$9,600	\$2,000	\$9,600	\$5,000
Family	\$19,200	\$5,000	\$19,200	\$12,500
Doctors' office visits: primary care physician selection not required				
Primary care office visit	\$15	30% after deductible	\$20	30% after deductible
Specialist office visit	\$25	30% after deductible	\$30 adult/\$20 child	30% after deductible
Diagnostic procedures				
Freestanding lab/radiology/ advanced imaging	\$0	30% after deductible	\$0	30% after deductible
Outpatient lab/radiology/ advanced imaging	\$0	30% after deductible	\$0	30% after deductible
Hospital care				
Inpatient admission	\$0	\$200/stay plus 30% after deductible	\$0	\$500/stay plus 30% after deductible
Outpatient department services/surgery	\$0	30% after deductible	\$0	30% after deductible
Emergency care				
Emergency room	\$100	\$100	\$125	\$125
Ambulance	10%	30% after deductible	10%	30% after deductible
Urgent care	\$25	30% after deductible	\$30 adult/\$20 child	30% after deductible
Other services				
Acupuncture	\$25	30% after deductible; lesser of \$60/visit or 75% of INN cost/visit	\$30 adult/\$20 child	30% after deductible; lesser of \$60/visit or 75% of INN cost/visit
Short-term therapies: Physical, occupational, speech, respiratory	\$25	30% after deductible for speech and occupational therapy; lesser of \$52/ visit or 75% of INN cost/ visit for physical therapy	\$30 adult/\$20 child	30% after deductible for speech and occupational therapy; lesser of \$52/ visit or 75% of INN cost/ visit for physical therapy
PT/OT/SP limits	Based on medical necessity		Based on medical necessity	
Chiropractic care	\$25	30% after deductible; lesser of \$35/visit or 75% of INN cost/visit	\$30 adult/\$20 child	30% after deductible; lesser of \$35/visit or 75% of INN cost/visit
Chiropractic limits	30-visit maximum per calendar year		30-visit maximum per calendar year	
Durable medical equipment	10%	30% after deductible	10%	30% after deductible
Out-of-network reimbursement	90% of FAIR Health national		90% of FAIR Health national	

¹Services performed at a hospital when not medically necessary will be covered at 50% after deductible in and out of network

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	Freedom 2035		Freedom HDLow	
Benefit	In network	Out of network	In network	Out of network
Medical network	Aetna Choice® POS II		Aetna Choice® POS II	
Deductible				
Individual	\$200	\$800	\$1,750*	\$1,750*
Family	\$500	\$2,000	\$3,500*	\$3,500*
Coinsurance	20%	40%	20%	40%
Maximum out-of-pocket limit				
Individual	\$9,600	\$6,500	\$2,750	\$3,750
Family	\$19,200	\$13,000	\$5,500	\$7,500
Doctors' office visits: primary care physician selection not required				
Primary care office visit	\$20	40% after deductible	20% after deductible	40% after deductible
Specialist office visit	\$35	40% after deductible	20% after deductible	40% after deductible
Diagnostic procedures				
Freestanding lab/radiology/ advanced imaging	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient lab/radiology/ advanced imaging	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Hospital care				
Inpatient admission	20% after deductible	\$600 copay plus 40% after deductible	20% after deductible	40% after deductible
Outpatient department services/surgery	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Emergency care				
Emergency room	\$300	\$300	20% after deductible	40% after deductible
Ambulance	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Urgent care	\$35	40% after deductible	20% after deductible	40% after deductible
Other services				
Acupuncture	\$35	40% after deductible; lesser of \$60/visit or 75% of INN cost/visit	20% after deductible	40% after deductible; lesser of \$60/visit or 75% of INN cost/visit
Short-term therapies: Physical, occupational, speech, respiratory	\$35 copay; 20% after deductible for outpatient facility	40% after deductible for speech and occupational therapy; lesser of \$52/ visit or 75% of INN cost/ visit for physical therapy	20% after deductible	40% after deductible for speech and occupational therapy; lesser of \$52/ visit or 75% of INN cost/ visit for physical therapy
PT/OT/SP limits	Based on medical necessity		Based on medical necessity	
Chiropractic care	\$35	40% after deductible; lesser of \$35/visit or 75% of INN cost/visit	20% after deductible	40% after deductible; lesser of \$35/visit or 75% of INN cost/visit
Chiropractic limits	30-visit maximum per calendar year		30-visit maximum per calendar year	
Durable medical equipment	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Out-of-network reimbursement	90% of FAIR Health national		90% of FAIR Health national	

*In- and out-of-network deductible combined; includes eligible prescription drug cost-shares.

• INN cost = in-network cost

	Freedom HDHigh		HMO
Benefit	In network	Out of network	In network
Medical network	Aetna Choice® POS II		Aetna Select SM
Deductible			
Individual	\$4,250*	\$4,250*	None
Family	\$8,500*	\$8,500*	None
Coinsurance	20%	40%	0%
Maximum out-of-pocket limit			
Individual	\$5,250	\$6,250	\$9,600
Family	\$10,500	\$12,500	\$19,200
Doctors' office visits: primary care physician selection not required			
Primary care office visit	20% after deductible	40% after deductible	\$10
Specialist office visit	20% after deductible	40% after deductible	\$10
Diagnostic procedures			
Freestanding lab/radiology/ advanced imaging	20% after deductible	40% after deductible	\$0
Outpatient lab/radiology/ advanced imaging	20% after deductible	40% after deductible	\$0
Hospital care			
Inpatient admission	20% after deductible	40% after deductible	\$0
Outpatient department services/surgery	20% after deductible	40% after deductible	\$0
Emergency care			
Emergency room	20% after deductible	40% after deductible	\$85
Ambulance	20% after deductible	40% after deductible	\$0
Urgent care	20% after deductible	40% after deductible	\$10
Other services			
Acupuncture	20% after deductible	40% after deductible; lesser of \$60/visit or 75% of INN cost/visit	Not covered
Short-term therapies: Physical, occupational, speech, respiratory	20% after deductible	40% after deductible for speech and occupational therapy; lesser of \$52/ visit or 75% of INN cost/ visit for physical therapy	\$10
PT/OT/SP limits	Based on medical necessity		60-visit maximum per calendar year
Chiropractic care	20% after deductible	40% after deductible; lesser of \$35/visit or 75% of INN cost/visit	\$10
Chiropractic limits	30-visit maximum per calendar year		20-visit maximum per calendar year
Durable medical equipment	20% after deductible	40% after deductible	\$100 deductible
Out-of-network reimbursement	90% of FAIR Health national		No out-of-network coverage

*In- and out-of-network deductible combined; includes eligible prescription drug cost-shares.

• INN cost = in-network cost

	26 Liberty Plus Tiered Network		26 Freedom	
Benefit	Tier 1	Tier 2 – Nationwide	In network	Out of network
Medical network	APCN+ Multi-Tier Open Access Aetna Select SM		Aetna Choice [®] POS II	
Deductible				
Individual	None	\$1,500	\$110	\$750
Family	None	\$3,000	\$220	\$1,500
Coinsurance	0%	20%	10%	30%
Maximum out-of-pocket limit				
Individual	\$2,500	\$4,500	\$9,880	\$2,500
Family	\$5,000	\$9,000	\$19,760	\$6,000
Doctors' office visits: primary care physician selection not required				
Primary care office visit	\$5	\$20	\$15	30% after deductible
Specialist office visit	\$15	\$30	\$15	30% after deductible
Diagnostic procedures				
Freestanding lab/radiology/advanced imaging	\$0	\$0	\$50 copay for radiology/advanced imaging	30% after deductible
Outpatient lab/radiology/advanced imaging	\$15	20% after deductible	\$50 copay for radiology/advanced imaging	30% after deductible
Hospital care				
Inpatient admission	\$150 per admission¹	20% after deductible¹	\$0	\$500/stay plus 30% after deductible
Outpatient department services/surgery	\$150¹	20% after deductible¹	\$0	30% after deductible
Emergency care				
Emergency room	\$100	\$100	\$150	\$150
Ambulance	\$0	\$0	10%	30% after deductible
Urgent care	\$15	\$30	\$15	30% after deductible
Other services				
Acupuncture	\$15	20% after deductible	\$15	30% after deductible; lesser of \$60/visit or 75% of INN cost/visit
Short-term therapies: Physical, occupational, speech, respiratory	\$5 office visit/\$15 outpatient facility	\$20 office visit/20% after deductible at outpatient facility	\$15	30% after deductible for speech and occupational therapy; lesser of \$52/visit or 75% of INN cost/visit for physical therapy
PT/OT/SP limits	30-visit maximum each per calendar year		Based on medical necessity	PT 20 visit maximum
Chiropractic care	\$15	\$30	\$15	30% after deductible; lesser of \$35/visit or 75% of INN cost/visit
Chiropractic limits	25-visit maximum per calendar year		30-visit maximum per calendar year	
Durable medical equipment	\$0	\$0	10%	30% after deductible
Out-of-network reimbursement	No out-of-network coverage		175% of CMS	

¹Services performed at a hospital when not medically necessary will be covered at 50% after deductible in and out of network

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	26 Freedom 10		26 Freedom 15	
Benefit	In network	Out of network	In network	Out of network
Medical network	Aetna Choice® POS II		Aetna Choice® POS II	
Deductible				
Individual	\$110	\$750	\$110	\$750
Family	\$220	\$1,500	\$220	\$1,500
Coinsurance	10%	20%	10%	30%
Coinsurance maximum out of pocket				
Individual	\$400	\$2,500	\$400	\$2,500
Family	\$1,000	\$6,000	\$1,000	\$6,000
Maximum out-of-pocket limit				
Individual	\$400	\$2,500	\$9,880	\$2,500
Family	\$1,000	\$6,000	\$19,760	\$6,000
Doctors' office visits: primary care physician selection not required				
Primary care office visit	\$10	20% after deductible	\$15	30% after deductible
Specialist office visit	\$10	20% after deductible	\$15	30% after deductible
Diagnostic procedures				
Freestanding lab	\$0	20% after deductible	\$0	30% after deductible
Freestanding radiology/ advanced imaging	\$50	20% after deductible	\$50	30% after deductible
Outpatient lab	\$0	20% after deductible	\$0	30% after deductible
Outpatient radiology/ advanced imaging	\$50	20% after deductible	\$50	30% after deductible
Hospital care				
Inpatient admission	\$0¹	\$200/stay plus 20% after deductible¹	\$0¹	\$200/stay plus 30% after deductible¹
Outpatient department services/surgery	\$0¹	20% after deductible¹	\$0¹	30% after deductible¹
Emergency care				
Emergency room	\$75	\$75	\$100	\$100
Ambulance	10%	20% after deductible	10%	30% after deductible
Urgent care	\$10	20% after deductible	\$15	30% after deductible
Other services				
Acupuncture	\$10	20% after deductible; lesser of \$60/visit or 75% of INN cost/visit	\$15	30% after deductible; lesser of \$60/visit or 75% of INN cost/visit
Short-term therapies: Physical, occupational, speech, respiratory	\$10	20% after deductible for speech and occupational therapy; lesser of \$52/ visit or 75% of INN cost/ visit for physical therapy	\$15	30% after deductible for speech and occupational therapy; lesser of \$52/ visit or 75% of INN cost/ visit for physical therapy
PT/OT/SP limits	Based on medical necessity	PT 20 visit maximum	Based on medical necessity	PT 20 visit maximum
Chiropractic care	\$10	20% after deductible; lesser of \$35/visit or 75% of INN cost/visit	\$15	30% after deductible; lesser of \$35/visit or 75% of INN cost/visit
Chiropractic limits	30-visit maximum per calendar year		30-visit maximum per calendar year	
Durable medical equipment	10%	20% after deductible	10%	30% after deductible
Out-of-network reimbursement	90% of FAIR Health national		90% of FAIR Health national	

¹Services performed at a hospital when not medically necessary will be covered at 50% after deductible in and out of network

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	26 Freedom 1525		26 Freedom 2030	
Benefit	In network	Out of network	In network	Out of network
Medical network	Aetna Choice® POS II		Aetna Choice® POS II	
Deductible				
Individual	\$110	\$750	\$110	\$750
Family	\$220	\$1,500	\$220	\$1,500
Coinsurance	10%	30%	10%	30%
Maximum out-of-pocket limit				
Individual	\$9,880	\$2,500	\$9,880	\$5,000
Family	\$19,760	\$6,000	\$19,760	\$12,500
Doctors' office visits: primary care physician selection not required				
Primary care office visit	\$15	30% after deductible	\$20	30% after deductible
Specialist office visit	\$25	30% after deductible	\$30 adult/\$20 child	30% after deductible
Diagnostic procedures				
Freestanding lab	\$0	30% after deductible	\$0	30% after deductible
Freestanding radiology/ advanced imaging	\$50	30% after deductible	\$50	30% after deductible
Outpatient lab	\$0	30% after deductible	\$0	30% after deductible
Outpatient radiology/ advanced imaging	\$50	30% after deductible	\$50	30% after deductible
Hospital care				
Inpatient admission	\$0¹	\$200/stay plus 30% after deductible¹	\$0¹	\$500/stay plus 30% after deductible¹
Outpatient department services/surgery	\$0¹	30% after deductible¹	\$0¹	30% after deductible¹
Emergency care				
Emergency room	\$100	\$100	\$125	\$125
Ambulance	10%	30% after deductible	10%	30% after deductible
Urgent care	\$25	30% after deductible	\$30 adult/\$20 child	30% after deductible
Other services				
Acupuncture	\$25	30% after deductible; lesser of \$60/visit or 75% of INN cost/visit	\$30 adult/\$20 child	30% after deductible; lesser of \$60/visit or 75% of INN cost/visit
Short-term therapies: Physical, occupational, speech, respiratory	\$25	30% after deductible for speech and occupational therapy; lesser of \$52/ visit or 75% of INN cost/ visit for physical therapy	\$30 adult/\$20 child	30% after deductible for speech and occupational therapy; lesser of \$52/ visit or 75% of INN cost/ visit for physical therapy
PT/OT/SP limits	Based on medical necessity	PT 20 visit maximum	Based on medical necessity	PT 20 visit maximum
Chiropractic care	\$25	30% after deductible; lesser of \$35/visit or 75% of INN cost/visit	\$30 adult/\$20 child	30% after deductible; lesser of \$35/visit or 75% of INN cost/visit
Chiropractic limits	30-visit maximum per calendar year		30-visit maximum per calendar year	
Durable medical equipment	10%	30% after deductible	10%	30% after deductible
Out-of-network reimbursement	90% of FAIR Health national		90% of FAIR Health national	

¹Services performed at a hospital when not medically necessary will be covered at 50% after deductible in and out of network

• INN cost = in-network cost



	26 Freedom 2035		26 Freedom HDLow	
Benefit	In network	Out of network	In network	Out of network
Medical network	Aetna Choice® POS II		Aetna Choice® POS II	
Deductible				
Individual	\$200	\$800	\$1,750*	\$1,750*
Family	\$500	\$2,000	\$3,500*	\$3,500*
Coinsurance	20%	40%	20%	40%
Maximum out-of-pocket limit				
Individual	\$9,880	\$6,500	\$2,750	\$3,750
Family	\$19,760	\$13,000	\$5,500	\$7,500
Doctors' office visits: primary care physician selection not required				
Primary care office visit	\$20	40% after deductible	20% after deductible	40% after deductible
Specialist office visit	\$35	40% after deductible	20% after deductible	40% after deductible
Diagnostic procedures				
Freestanding lab	\$0	40% after deductible	20% after deductible	40% after deductible
Freestanding radiology/ advanced imaging	\$50	40% after deductible	20% after deductible	40% after deductible
Outpatient lab	\$0	40% after deductible	20% after deductible	40% after deductible
Outpatient radiology/ advanced imaging	\$50	40% after deductible	20% after deductible	40% after deductible
Hospital care				
Inpatient admission	20% after deductible¹	\$600 copay plus 40% after deductible¹	20% after deductible¹	40% after deductible¹
Outpatient department services/surgery	20% after deductible¹	40% after deductible¹	20% after deductible¹	40% after deductible¹
Emergency care				
Emergency room	\$300	\$300	20% after deductible	40% after deductible
Ambulance	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Urgent care	\$35	40% after deductible	20% after deductible	40% after deductible
Other services				
Acupuncture	\$35	40% after deductible; lesser of \$60/visit or 75% of INN cost/visit	20% after deductible	40% after deductible; lesser of \$60/visit or 75% of INN cost/visit
Short-term therapies: Physical, occupational, speech, respiratory	\$35	40% after deductible for speech and occupational therapy; lesser of \$52/visit or 75% of INN cost/visit for physical therapy	20% after deductible	40% after deductible for speech and occupational therapy; lesser of \$52/visit or 75% of INN cost/visit for physical therapy
PT/OT/SP limits	Based on medical necessity	PT 20 visit maximum	Based on medical necessity	PT 20 visit maximum
Chiropractic care	\$35	40% after deductible; lesser of \$35/visit or 75% of INN cost/visit	20% after deductible	40% after deductible; lesser of \$35/visit or 75% of INN cost/visit
Chiropractic limits	30-visit maximum per calendar year		30-visit maximum per calendar year	
Durable medical equipment	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Out-of-network reimbursement	90% of FAIR Health national		90% of FAIR Health national	

*In- and out-of-network deductible combined; includes eligible prescription drug cost-shares.

¹Services performed at a hospital when not medically necessary will be covered at 50% after deductible in and out of network

• INN cost = in-network cost

Benefit	26 Freedom HDHigh		26 HMO
	In network	Out of network	In network
Medical network		Aetna Choice® POS II	Aetna Select™
Deductible			
Individual	\$4,250*	\$4,250*	None
Family	\$8,500*	\$8,500*	None
Coinsurance	20%	40%	0%
Maximum out-of-pocket limit			
Individual	\$5,250	\$6,250	\$9,880
Family	\$10,500	\$12,500	\$19,670
Doctors' office visits: primary care physician selection not required			
Primary care office visit	20% after deductible	40% after deductible	\$10
Specialist office visit	20% after deductible	40% after deductible	\$10
Diagnostic procedures			
Freestanding lab/radiology/advanced imaging	20% after deductible	40% after deductible	\$0
Outpatient lab/radiology/advanced imaging	20% after deductible	40% after deductible	\$0
Hospital care			
Inpatient admission	20% after deductible¹	40% after deductible¹	\$0¹
Outpatient department services/surgery	20% after deductible¹	40% after deductible¹	\$0¹
Emergency care			
Emergency room	20% after deductible	40% after deductible	\$85
Ambulance	20% after deductible	40% after deductible	\$0
Urgent care	20% after deductible	40% after deductible	\$10
Other services			
Acupuncture	20% after deductible	40% after deductible; lesser of \$60/visit or 75% of INN cost/visit	Not covered
Short-term therapies: Physical, occupational, speech, respiratory	20% after deductible	40% after deductible for speech and occupational therapy; lesser of \$52/visit or 75% of INN cost/visit for physical therapy	\$10
PT/OT/SP limits	Based on medical necessity	PT 20 visit maximum	60-visit maximum per calendar year
Chiropractic care	20% after deductible	40% after deductible; lesser of \$35/visit or 75% of INN cost/visit	\$10
Chiropractic limits	30-visit maximum per calendar year		20-visit maximum per calendar year
Durable medical equipment	20% after deductible	40% after deductible	\$100 deductible
Out-of-network reimbursement	90% of FAIR Health national		No out-of-network coverage

*In- and out-of-network deductible combined; includes eligible prescription drug cost-shares.

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• INN cost = in-network cost