

26 Liberty Plus Tiered Network			26 CWA Unity 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 ¹	\$750
Family	None	\$3,000	\$220 ¹	\$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	\$20	\$35	\$30	30% after deductible
Diagnostic procedures				
Freestanding lab	\$0	\$0	\$0	30% after deductible
Freestanding radiology/ advanced imaging	\$0	\$0	\$50	30% after deductible
Outpatient lab	\$20	20% after deductible	\$0	30% after deductible
Outpatient radiology/ advanced imaging	\$20	20% after deductible	\$50	30% after deductible
Hospital care				
Inpatient admission	\$150 per admission ²	20% after deductible ²	\$0 ²	\$500/stay plus 30% after deductible ²
Outpatient department services/surgery	\$150 ²	20% after deductible ²	\$0 ²	30% after deductible ²
Emergency care				
Emergency room	\$100	\$100	\$150	\$150
Ambulance	\$0	\$0	10%	30% after deductible
Urgent care	\$35	\$50	\$45	30% after deductible
Other services				
Acupuncture	\$20	20% after deductible	\$30	30% after deductible; lesser of \$60 visit or 75% of INN cost/visit
Short-term therapies: Physical, occupational, speech, respiratory	\$20 office visit/\$20 outpatient facility	\$35 office visit/20% after deductible at outpatient facility	\$30	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	\$20	\$35	\$30	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	

¹Deductible applies to all services which do not apply a copay.

²Services 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.
- This is not a complete list of covered services. Exclusions and limitations apply to some services.
Visit NJ.gov/treasury/pensions/member-guidebooks.shtml for more information.

Visit AetnaStateNJ.com or call 1-877-782-8365 (TTY: 711) for more information.

26 Freedom			26 Freedom 15		
Benefit	In network	Out of network	In network	Out of network	
Medical network			Aetna Choice® POS II		
Deductible			Aetna Choice® POS II		
Individual	\$110 ¹	\$750	\$110 ¹	\$750	
Family	\$220 ¹	\$1,500	\$220 ¹	\$1,550	
Coinsurance	10%	30%	10%	30%	
Maximum out-of-pocket limit					
Individual	\$9,880	\$2,500	\$9,880	\$2,500	
Family	\$19,760	\$6,000	\$19,760	\$6,000	
Doctors' office visits: primary care physician selection not required					
Primary care office visit	\$15	30% after deductible	\$15	30% after deductible	
Specialist office visit	\$30	30% after deductible	\$15	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	\$0 ²	\$500/stay plus 30% after deductible ²	\$0 ²	\$200/stay plus 30% after deductible ²	
Outpatient department services/surgery	\$0 ²	30% after deductible ²	\$0 ²	30% after deductible ²	
Emergency care					
Emergency room	\$150	\$150	\$100	\$100	
Ambulance	10%	30% after deductible	10%	30% after deductible	
Urgent care	\$45	30% after deductible	\$15	30% after deductible	
Other services					
Acupuncture	\$30	30% 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	\$30	30% 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	20 visit maximum	Based on medical necessity	PT 20 visit maximum	
Chiropractic care	\$30	30% 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%	30% after deductible	10%	30% after deductible	
Out-of-network reimbursement	175% of CMS		90% of FAIR Health national		

¹Deductible applies to all services which do not apply a copay.

²Services 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 1525			26 Freedom 2030		
Benefit	In network	Out of network	In network	Out of network	
Medical network			Aetna Choice® POS II		
Deductible			Aetna Choice® POS II		
Individual	\$110 ¹	\$750	\$110 ¹	\$750	
Family	\$220 ¹	\$1,500	\$220 ¹	\$1,500	
Coinsurance	10% ²	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	\$0 ²	\$200/stay plus 30% after deductible ²	\$0 ²	\$500/stay plus 30% after deductible ²	
Outpatient department services/surgery	\$0 ²	30% after deductible ²	\$0 ²	30% after deductible ²	
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		

¹Deductible applies to all services which do not apply a copay.²Services 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	\$200¹	\$800	\$1,750*	\$1,750*
Family	\$500¹	\$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/radiology/advanced imaging	\$0	40% after deductible	20% after deductible	40% after deductible
Freestanding lab/radiology/advanced imaging	\$50	40% after deductible	20% after deductible	40% after deductible
Outpatient lab/radiology/advanced imaging	\$0	40% after deductible	20% after deductible	40% after deductible
Outpatient lab/radiology/advanced imaging	\$50	40% after deductible	20% after deductible	40% after deductible
Hospital care				
Inpatient admission	20% after deductible²	\$600/stay plus 40% after deductible²	20% after deductible²	40% after deductible²
Outpatient department services/surgery	20% after deductible²	40% after deductible²	20% after deductible²	40% after deductible²
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.

¹Deductible applies to all services which do not apply a copay.

²Services 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 HDHigh			26 HMO
Benefit	In network	Out of network	In network
Medical network			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	\$9,880
Family	\$10,500	\$12,500	\$19,760
Doctors' office visits: primary care physician selection not required			Required
Primary care office visit	20% after deductible	40% after deductible	\$15
Specialist office visit	20% after deductible	40% after deductible	\$30
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 ¹	40% after deductible ¹	\$0 ¹
Outpatient department services/surgery	20% after deductible ¹	40% after deductible ¹	\$0 ¹
Emergency care			
Emergency room	20% after deductible	40% after deductible	\$100
Ambulance	20% after deductible	40% after deductible	\$0
Urgent care	20% after deductible	40% after deductible	\$45
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	\$30
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	\$30
Chiropractic limits	30-visit maximum per calendar year		20 visit maximum
Durable medical equipment	20% after deductible	40% after deductible	\$100 deductible
Out-of-network reimbursement			No out-of-network coverage

*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.