



Explore Your Benefits

UNION NEGOTIATED AND NON-ALIGNED PLANS MEDICAL PLAN DESIGN - PLAN YEAR 2027 STATE ACTIVE GROUP

HA-1059-0926

Side-by-Side Medical Comparison	26 Aetna Freedom	26 Horizon NJ 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	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% ⁶	20% ⁶	20% ⁶	20% ⁶
In-Network Coinsurance Maximum (Individual/Family)	\$1,000/\$2,000	\$1,000/\$2,000	\$1,000/\$2,000	\$1,000/\$2,000
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 Unity Freedom and 26 Horizon 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.

- 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.