



**STATE ACTIVE GROUP
MEDICAL PLAN DESIGN - PLAN YEAR 2026**

Explore Your Benefits

| Side-by-Side Medical Comparison | 26 Aetna Freedom | 26 Horizon NJ DIRECT | 26 Aetna Freedom 15 | 26 Horizon NJ DIRECT 15 | 26 Aetna Freedom 1525 | 26 Horizon NJ DIRECT 1525 |
|---|--|--|--|--|--|--|
| Primary Care Copayment | \$15 | \$15 | \$15 | \$15 | \$15 | \$15 |
| Specialist Care Copayment | \$30 | \$30 | \$15 | \$15 | \$25 | \$25 |
| Emergency Room Copayment | \$150 ¹ | \$150 ¹ | \$100 | \$100 | \$100 | \$100 |
| In-Network Deductible | \$110 (individual)/ \$220 (family) ² |
| In-Network Coinsurance | 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) | \$8,480/\$16,960 | \$8,480/\$16,960 | \$8,480/\$16,960 | \$8,480/\$16,960 | \$8,480/\$16,960 | \$8,480/\$16,960 |
| 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 ⁴ | 30% | 30% | 30% | 30% | 30% | 30% |
| Out-of-Network Out-of-Pocket Maximum (Individual/Family) ⁵ | \$2,500/\$6,000 | \$2,500/\$6,000 | \$2,500/\$6,000 | \$2,500/\$6,000 | \$2,500/\$6,000 | \$2,500/\$6,000 |
| Out-of-Network Inpatient Hospital Deductible | \$500/stay | \$500/stay | \$200/stay | \$200/stay | \$200/stay | \$200/stay |



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| Side-by-Side Medical Comparison | 26 Aetna Freedom 2030 | 26 Horizon NJ DIRECT 2030 | 26 Aetna Freedom 2035 | 26 Horizon NJ DIRECT 2035 | 26 Aetna HMO | 26 Horizon HMO ⁶ |
|---|--|--|--------------------------|---------------------------|--|--|
| Primary Care Copayment | \$20 | \$20 | \$20 | \$20 | \$15 | \$15 |
| Specialist Care Copayment | \$30 adult/ \$20 child 26 and under | \$30 adult/ \$20 child 26 and under | \$35 | \$35 | \$30 | \$30 |
| Emergency Room Copayment | \$125 | \$125 | \$300 | \$300 | \$100 | \$100 |
| In-Network Deductible | \$110 (individual)/ \$220 (family) ² | \$110 (individual)/ \$220 (family) ² | \$200/\$500 ⁷ | \$200/\$500 ⁷ | \$100 per individual for Durable Medical Equipment | \$100 per individual for Durable Medical Equipment |
| In-Network Coinsurance | 10% ³ | 10% ³ | 20% after deductible | 20% after deductible | None | None |
| In-Network Coinsurance Maximum (Individual/Family) | \$800/\$2,000 | \$800/\$2,000 | \$2,000/\$5,000 | \$2,000/\$5,000 | None | None |
| In-Network Out-of-Pocket Maximum (Individual/Family) | \$8,480/\$16,960 | \$8,480/\$16,960 | \$8,480/\$16,960 | \$8,480/\$16,960 | \$8,480/\$16,960 | \$8,480/\$16,960 |
| Out-of-Network Deductible (Individual/Family) | \$750/\$1,500 | \$750/\$1,500 | \$800/\$2,000 | \$800/\$2,000 | | |
| Out-of-Network Coinsurance ⁴ | 30% | 30% | 40% | 40% | | |
| Out-of-Network Out-of-Pocket Maximum (Individual/Family) ⁵ | \$5,000/\$12,500 | \$5,000/\$12,500 | \$6,500/\$13,000 | \$6,500/\$13,000 | | |
| Out-of-Network Inpatient Hospital Deductible | \$500/stay | \$500/stay | \$600/stay | \$600/stay | | |



STATE ACTIVE GROUP MEDICAL PLAN DESIGN - PLAN YEAR 2026

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| Side-by-Side Medical Comparison | 26 Aetna Liberty Plus | | 26 Horizon OMNIA | | 26 Aetna Freedom HDHigh* | 26 Horizon NJ DIRECT HDHigh* | 26 Aetna Freedom HDLow* | 26 Horizon NJ DIRECT HDLow* |
|---|-----------------------|----------------------|----------------------|----------------------|--|--|--|--|
| | TIER 1 | TIER 2 | TIER 1 | TIER 2 | | | | |
| Primary Care Copayment | \$5 | \$20 | \$5 | \$20 | 20% coinsurance after deductible |
| Specialist Care Copayment | \$20 | \$35 | \$20 | \$35 | 20% coinsurance after deductible |
| Emergency Room Copayment | \$100 | \$100 | \$100 | \$100 | 20% coinsurance after deductible |
| In-Network Deductible | None | \$1,500 ⁸ | None | \$1,500 ⁸ | \$4,200 ⁸ | \$4,200 ⁸ | \$1,700 ⁸ | \$1,700 ⁸ |
| In-Network Coinsurance | None | 20% | None | 20% | 20% after deductible | 20% after deductible | 20% after deductible | 20% after deductible |
| In-Network Coinsurance Maximum (Individual/Family) | None | None | None | None | \$1,000/\$2,000 | \$1,000/\$2,000 | \$1,000/\$2,000 | \$1,000/\$2,000 |
| In-Network Out-of-Pocket Maximum (Individual/Family) | \$2,500 ⁸ | \$4,500 ⁸ | \$2,500 ⁸ | \$4,500 ⁸ | \$5,200/\$10,400 | \$5,200/\$10,400 | \$2,700/\$5,400 | \$2,700/\$5,400 |
| Out-of-Network Deductible (Individual/Family) | | | | | See In-Network Deductible ⁹ |
| Out-of-Network Coinsurance ⁴ | | | | | 40% | 40% | 40% | 40% |
| Out-of-Network Out-of-Pocket Maximum (Individual/Family) ⁵ | | | | | \$6,200/\$12,400 | \$6,200/\$12,400 | \$3,700/\$7,400 | \$3,700/\$7,400 |
| Out-of-Network Inpatient Hospital Deductible | | | | | None | None | None | None |

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 Service area for Horizon HMO plans are limited to New Jersey, New Castle County in Delaware, and bordering counties of Pennsylvania and New York.

⁷ Applies to services that don't require a copayment.

⁸ Family amounts are 2x member amounts listed in table.

⁹ Out-of-network deductible is combined with in-network deductible.