

STATE ACTIVE EMPLOYEES — MEDICAL PLAN DESIGNS — PLAN YEAR 2016

HA-0895-1015

AETNA PLANS and HORIZON PLANS

	Aetna Freedom15 NJ DIRECT15	Aetna Freedom1525 NJ DIRECT1525	Aetna Freedom2030 NJ DIRECT2030	Aetna Freedom2035 NJ DIRECT2035	Aetna HMO Horizon HMO¹	Aetna Liberty Horizon OMNIA	Aetna Value HD4000* NJ DIRECT HD4000*	Aetna Value HD1500* NJ DIRECT HD1500*
Medical Cost Sharing						TIER1 / TIER 2		
Primary Care Copayment	\$15	\$15	\$20	\$20	\$15	\$5.00/\$20.00		
Specialist Care Copayment	\$15	\$25	\$30 adult / \$20 child**	\$35	\$15	\$15.00/\$30.00		
Emergency Room Copayment	\$75	\$100	\$125	\$300	\$75	\$100.00/\$100.00		
In-Network Deductible				\$200 ⁶	\$100 ²	None/\$1,500.00 ⁸	\$4,000	\$1,500
In-Network Coinsurance ²	10%	10%	10%	20% ⁶ after deductible		None/20%	20% ⁶ after deductible	20% ⁶ after deductible
In-Network Coinsurance Maximum (Individual/Family)	\$400/\$1,000	\$400/\$1,000	\$800/\$2,000	\$2,000/\$5,000		None/None	\$1,000/\$2,000	\$1,000/\$2,000
In-Network Out-of-Pocket Maximum (Individual/Family)	\$5,480/\$10,960	\$5,480/\$10,960	\$5,480/\$10,960	\$5,480/\$10,960	\$5,480/\$10,960	\$2,500 ⁸ /\$4,500 ⁸	\$5,000/\$10,000	\$5,000/\$10,000
Out-of-Network Deductible (Individual)	\$100	\$100	\$200	\$800		NA / NA	See In-Network Deductible ⁵	See In-Network Deductible ³
Out-of-Network Coinsurance ⁴	30%	30%	30%	40%		NA / NA	40%	40%
Out-of-Network Out-of-Pocket Maximum (Individual/Family)	\$2,000/\$5,000	\$2,000/\$5,000	\$5,000/\$12,500	\$6,500/\$13,000		NA / NA	\$6,000/\$12,000	\$3,500/\$7,000
Out-of-Network Inpatient Hospital Deductible	\$200/stay	\$200/stay	\$500/stay	\$600/stay		NA / NA		
Employer Health Savings Account Funding ⁵						NA / NA		\$300
Prescription Drug Copayments								
Retail: Generic Copayments	\$3.00	\$7.00	\$3.00	\$7.00	\$3.00	\$7.00	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Retail: Brand Copayments	\$10.00	\$16.00	\$18.00	\$21.00	\$10.00	\$16.00		
Retail: Brand w/Generic available Copayments	\$25.00	\$35.00	\$46.00	member pays difference ⁷	\$25.00	\$35.00		
Mail: Generic Copayments	\$5.00	\$18.00	\$5.00	\$18.00	\$5.00	\$18.00		
Mail: Brand Copayments	\$15.00	\$40.00	\$36.00	\$52.00	\$15.00	\$40.00		
Mail: Brand w/Generic available Copayments	\$40.00	\$88.00	\$92.00	member pays difference ⁷	\$40.00	\$88.00		
Prescription Drug annual Out-of- Pocket Maximum(Individual/Family.)	\$1,370/\$2,740	\$1,370/\$2,740	\$1,370/\$2,740	\$1,370/\$2,740	\$1,370/\$2,740	\$1,370/\$2,740		

* HD = High Deductible Health Plan

** Age 26 and under

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 On select services.

³ Out-of-Network Deductible is combined with In-Network Deductible.

⁴ After Deductible

⁵ Health Savings Accounts can be used for qualified medical expenses without federal tax liability.

⁶ Applies to services that do not require a copayment.

⁷ You pay the applicable generic copayment as listed above, plus the cost difference between the brand drug and the generic drug.

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