STATE ACTIVE EMPLOYEES — MEDICAL PLAN DESIGNS — PLAN YEAR 2017

HA-0895-1016

AETNA PLANS and HORIZON PLANS

	Aetna Freedom15 NJ DIRECT15	Aetna Freedom1525 NJ DIRECT1525	Aetna Freedom2030 NJ DIRECT2030	Aetna Freedom2035 NJ DIRECT2035	Aetna HMO Horizon HMO[1]	Aetna Liberty Horizon OMNIA	Aetna Value HD4000* NJ DIRECT HD4000*	Aetna Value HD1500* NJ DIRECT HD1500*
Medical Cost Sharing						**TIER 1 / 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	$100	$100	$125	$300	$100	$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)	$5,720/$11,440	$5,720/$11,440	$5,720/$11,440	$5,720/$11,440	$5,720/$11,440	$2,500[8]/$4,500[8]	$5,000/$10,000	$2,500/$5,000
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.)	$1,430/$2,860	$1,430/$2,860	$1,430/$2,860	$1,430/$2,860	$1,430/$2,860	$1,430/$2,860		

*** 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.

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