



# STATE RETIRED GROUP MEDICAL PLAN DESIGN - PLAN YEAR 2024

Side-by-Side Medical Comparison	Aetna Freedom*	Horizon NJ DIRECT*	Aetna Freedom10*	Horizon NJ DIRECT10*	Aetna Freedom15*	Horizon NJ DIRECT15*
Primary Care Copayment	\$15	\$15	\$10	\$10	\$15	\$15
Specialist Care Copayment	\$15	\$15	\$10	\$10	\$15	\$15
Urgent Care Copayment	\$15	\$15	\$10	\$10	\$15	\$15
Emergency Room Copayment	\$150	\$150	\$75	\$75	\$100	\$100
In-Network Deductible (Individual/Family)	None	None	None	None	None	None
In-Network Coinsurance	10% <sup>1</sup>	10% <sup>1</sup>	10% <sup>1</sup>	10% <sup>1</sup>	10% <sup>1</sup>	10% <sup>1</sup>
In-Network Coinsurance Maximum (Individual/Family)	\$800/\$2,000	\$800/\$2,000	None	None	\$400/\$1,000	\$400/\$1,000
In-Network Out-of-Pocket Maximum (Individual/Family)	\$8,099/\$16,198	\$8,099/\$16,198	\$400/\$1,000	\$400/\$1,000	\$8,099/\$16,198	\$8,099/\$16,198
Out-of-Network Deductible (Individual/Family)	\$400/\$1,000	\$400/\$1,000	\$100/\$250	\$100/\$250	\$100/\$250	\$100/\$250
Out-of-Network Coinsurance <sup>2</sup>	30%	30%	20%	20%	30%	30%
Out-of-Network Out-of-Pocket Maximum (Individual/Family)	\$2,000/\$5,000	\$2,000/\$5,000	\$2,000/\$5,000	\$2,000/\$5,000	\$2,000/\$5,000	\$2,000/\$5,000
Out-of-Network Inpatient Hospital Deductible	\$500/stay	\$500/stay	\$200/stay	\$200/stay	\$200/stay	\$200/stay



# STATE RETIRED GROUP MEDICAL PLAN DESIGN - PLAN YEAR 2024

Side-by-Side Medical Comparison	Aetna Freedom1525	Horizon NJ DIRECT1525	Aetna Freedom2030	Horizon NJ DIRECT2030	Aetna HMO <sup>3</sup>	Horizon HMO <sup>3</sup>
Primary Care Copayment	\$15	\$15	\$20	\$20	\$10	\$10
Specialist Care Copayment	\$25	\$25	\$30/adult \$20/child**	\$30/adult \$20/child**	\$10	\$10
Urgent Care Copayment	\$25	\$25	\$30/adult \$20/child**	\$30/adult \$20/child**	\$10	\$10
Emergency Room Copayment	\$100	\$100	\$125	\$125	\$85	\$85
In-Network Deductible (Individual/Family)	None	None	None	None	None	None
In-Network Coinsurance	10% <sup>1</sup>	10% <sup>1</sup>	10% <sup>1</sup>	10% <sup>1</sup>	10% <sup>1</sup>	10% <sup>1</sup>
In-Network Coinsurance Maximum (Individual/Family)	\$400/\$1,000	\$400/\$1,000	\$800/\$2,000	\$800/\$2,000	None	None
In-Network Out-of-Pocket Maximum (Individual/Family)	\$8,099/\$16,198	\$8,099/\$16,198	\$8,099/\$16,198	\$8,099/\$16,198	\$8,099/\$16,198	\$8,099/\$16,198
Out-of-Network Deductible (Individual/Family)	\$100/\$250	\$100/\$250	\$200/\$500	\$200/\$500		
Out-of-Network Coinsurance <sup>2</sup>	30%	30%	30%	30%		
Out-of-Network Out-of-Pocket Maximum (Individual/Family)	\$2,000/\$5,000	\$2,000/\$5,000	\$5,000/\$12,500	\$5,000/\$12,500		
Out-of-Network Inpatient Hospital Deductible	\$200/stay	\$200/stay	\$500/stay	\$500/stay		





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Side-by-Side Medical Comparison	Aetna Freedom HDHigh*	Horizon NJ DIRECT HDHigh*	Aetna Freedom HDLow*	Horizon NJ DIRECT HDLow*
Primary Care Copayment	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Specialist Care Copayment	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Urgent Care Copayment	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Emergency Room Copayment	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
In-Network Deductible (Individual/Family)	\$4,100/\$8,200	\$4,100/\$8,200	\$1,600/\$3,200	\$1,600/\$3,200
In-Network Coinsurance	20% <sup>1</sup>	20% <sup>1</sup>	20% <sup>1</sup>	20% <sup>1</sup>
In-Network Coinsurance Maximum (Individual/Family)	None	None	None	None
In-Network Out-of-Pocket Maximum (Individual/Family)	\$5,100/\$10,200	\$5,100/\$10,200	\$2,600/\$5,200	\$2,600/\$5,200
Out-of-Network Deductible (Individual/Family)	See In-Network Deductible <sup>4</sup>	See In-Network Deductible <sup>4</sup>	See In-Network Deductible <sup>4</sup>	See In-Network Deductible <sup>4</sup>
Out-of-Network Coinsurance <sup>2</sup>	40%	40%	40%	40%
Out-of-Network Out-of-Pocket Maximum (Individual/Family)	\$6,100/\$12,200	\$6,100/\$12,200	\$3,600/\$7,200	\$3,600/\$7,200
Out-of-Network Inpatient Hospital Deductible	None	None	None	None

\* Medicare-eligible retirees and/or Medicare-eligible spouses of retirees will be enrolled in a corresponding plan. Please view corresponding Medicare Retiree chart for more information.

\*\* Age 26 and under

<sup>1</sup> On select services. Please see plan guidebook.

<sup>2</sup> After deductible.

<sup>3</sup> Service areas for Horizon HMO plans are limited to New Jersey, New Castle County in Delaware, and border-

ing counties of Pennsylvania and New York. Aetna HMO plans are not limited to this service area and utilize Aetna's nationwide Aetna Select network.

<sup>4</sup> Out-of-network deductible is combined with in-network deductible.

**Note:** Medicare enrollees can review the Medicare Advantage plan designs at Aetna's website: [www.aetnastatenj.com](http://www.aetnastatenj.com) All plans available to Medicare eligible members can be found on our website via the corresponding Medicare plan comparison chart.