



**LOCAL GOVERNMENT ACTIVE GROUP
MEDICAL PLAN DESIGN - PLAN YEAR 2024**

Explore Your Benefits

| Aetna Plan Options (Available July 1, 2024) | Freedom / Freedom 2019* | Freedom10 | Freedom15 | Freedom1525 | Freedom2030 | Freedom2035 | Aetna HMO | Aetna Liberty Plus | | Freedom HDHigh** | Freedom HDLow** |
|---|--|------------------|------------------|------------------|--------------------------|--------------------------|--------------------------|----------------------|----------------------|--|--|
| Horizon Plan Options | NJ DIRECT/ NJ DIRECT 2019* | NJ DIRECT10 | NJ DIRECT15 | NJ DIRECT1525 | NJ DIRECT2030 | NJ DIRECT2035 | Horizon HMO ¹ | Horizon OMNIA | | NJ DIRECT HDHigh** | NJ DIRECT HDLow** |
| Medical Cost Sharing | | | | | | | | TIER 1 | TIER 2 | | |
| Primary Care Copayment | \$15 | \$10 | \$15 | \$15 | \$20 | \$20 | \$10 | \$5 | \$20 | 20% coinsurance after deductible | 20% coinsurance after deductible |
| Specialist Care Copayment | \$15 | \$10 | \$15 | \$25 | \$30 adult/\$20 child*** | \$35 | \$10 | \$15 | \$30 | 20% coinsurance after deductible | 20% coinsurance after deductible |
| Emergency Room Copayment | \$150 ⁷ | \$75 | \$100 | \$100 | \$125 | \$300 | \$85 | \$100 | \$100 | 20% coinsurance after deductible | 20% coinsurance after deductible |
| In-Network Deductible | \$100 ⁸ (if hired after 7/1/19) | None | None | None | None | \$200/\$500 ³ | None | None | \$1,500 ⁶ | \$4,100 ⁶ | \$1,600 ⁶ |
| In-Network Coinsurance | 10% ² | 10% ² | 10% ² | 10% ² | 10% ² | 20% after deductible | 0% ² | None | 20% | 20% after deductible | 20% after deductible |
| In-Network Coinsurance Maximum (Individual/Family) | \$800/\$2,000 | \$400/\$1,000 | \$400/\$1,000 | \$400/\$1,000 | \$800/\$2,000 | \$2,000/\$5,000 | \$0 | None | None | \$1,000/\$2,000 | \$1,000/\$2,000 |
| In-Network Out-of-Pocket Maximum (Individual/Family) | \$7,560/\$15,120 | \$400/\$1,000 | \$7,560/\$15,120 | \$7,560/\$15,120 | \$7,560/\$15,120 | \$7,560/\$15,120 | \$7,560/\$15,120 | \$2,500 ⁶ | \$4,500 ⁶ | \$5,100/\$10,200 | \$2,600/\$5,200 |
| Out-of-Network Deductible (Individual/Family) | \$400/\$1,000 | \$100/\$250 | \$100/\$250 | \$100/\$250 | \$200/\$500 | \$800/\$2,000 | | | | See In-Network Deductible ⁴ | See In-Network Deductible ⁴ |
| Out-of-Network Coinsurance ⁵ | 30% | 20% | 30% | 30% | 30% | 40% | | | | 40% | 40% |
| Out-of-Network Out-of-Pocket Maximum (Individual/Family) ⁹ | \$2,000/\$5,000 | \$2,000/\$5,000 | \$2,000/\$5,000 | \$2,000/\$5,000 | \$5,000/\$12,500 | \$6,500/\$13,000 | | | | \$6,100/\$12,200 | \$3,600/\$7,200 |
| Out-of-Network Inpatient Hospital Deductible | \$500 | \$200/stay | \$200/stay | \$200/stay | \$500/stay | \$600/stay | | | | | |

* Members hired before July 1, 2019, will be enrolled in Freedom or NJ DIRECT. Members hired after July 1, 2019, will be enrolled in Freedom 2019 or NJ DIRECT 2019.

** 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 Applies to services that do not require a copayment.

⁴ Out-of-Network Deductible is combined with In-Network Deductible.

⁵ After Deductible

⁶ Family amounts are 2 x member amounts listed in table.

⁷ \$50 for adults referred to the emergency room by their primary care physician or for children (through age 19) referred by their pediatrician.

⁸ \$100 in network deductible has exclusions: 2nd wellness visit, preventive, obstetrics, pediatrics, and any deductible applied to other services.

⁹ All plans with out-of-network benefits have specified dollar limits for chiropractic, physical therapy, and acupuncture.



**LOCAL GOVERNMENT ACTIVE GROUP
PRESCRIPTION PLAN DESIGN - PLAN YEAR 2024**

Explore Your Benefits

| Aetna Plan Options (Available July 1, 2024) | Freedom / Freedom 2019† | Freedom10 | Freedom15 | Freedom1525 | Freedom2030 | Freedom2035 | Aetna HMO | Aetna Liberty Plus | Freedom HDHigh* | Freedom HDLow* |
|--|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|---------------------------------------|-------------------------------------|-------------------------------------|---------------------------------------|---------------------------------------|
| Horizon Plan Options | NJ DIRECT/ NJ DIRECT 2019† | NJ DIRECT10 | NJ DIRECT15 | NJ DIRECT1525 | NJ DIRECT2030 | NJ DIRECT2035 | Horizon HMO ¹ | Horizon OMNIA | NJ DIRECT HDHigh* | NJ DIRECT HDLow* |
| Prescription Drug Copayments ² | | | | | | | | | | |
| Retail: Generic Copayments | \$7 | \$3 | \$3 | \$7 | \$3 | \$7 ³ | \$3 | \$7 | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| Retail: Preferred Brand Copayments | \$16 | \$10 | \$10 | \$16 | \$18 | \$21 ³ | \$10 | \$16 | | |
| Retail: Non-Preferred Brand Copayments | Member pays difference ⁴ | \$10 | \$10 | \$35 | \$46 | Member pays difference ^{3,4} | \$10 | \$35 | | |
| Retail: Brand w/ Generic Equivalent | Member pays difference ⁴ | Member pays difference ⁴ | Member pays difference ⁴ | Member pays difference ⁴ | Member pays difference ⁴ | Member pays difference ^{3,4} | Member pays difference ⁴ | Member pays difference ⁴ | | |
| Mail: Generic Copayments | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | | |
| Mail: Preferred Brand Copayments | \$40 | \$15 | \$15 | \$40 | \$36 | \$52 | \$15 | \$40 | | |
| Mail: Non-Preferred Brand Copayments | Member pays difference ⁴ | \$15 | \$15 | \$88 | \$92 | Member pays difference ^{3,4} | \$15 | \$88 | | |
| Mail: Brand w/ Generic Equivalent | Member pays difference ⁴ | Member pays difference ⁴ | Member pays difference ⁴ | Member pays difference ⁴ | Member pays difference ⁴ | Member pays difference ^{3,4} | Member pays difference ⁴ | Member pays difference ⁴ | | |
| Prescription Drug annual Out-of-Pocket Maximum (Individual/Family) | \$1,890/\$3,780 | \$1,890/\$3,780 | \$1,890/\$3,780 | \$1,890/\$3,780 | \$1,890/\$3,780 | \$1,890/\$3,780 | \$1,890/\$3,780 | \$1,890/\$3,780 | | |

Note: Retail – 30 day supply. Mail – 90 day supply. Oral contraceptive coverage is available under the medical and prescription plans.

† **Members hired before July 1, 2019 will be enrolled in Freedom or NJ DIRECT. Members hired after July 1, 2019 will be enrolled in Freedom 2019 or NJ DIRECT 2019.**

* **HD = High Deductible Health Plan**

¹ Service areas for the Horizon HMO plan are limited to New Jersey, New Castle County in Delaware, and bordering counties of Pennsylvania and New York.

² Local government employers can select from the SHBP's Prescription Drug Plans, purchase their own prescription drug coverage plan, or receive prescription drug coverage through the SHBP medical plan. Copayments shown apply to the plans when coverage is through the SHBP's Prescription Drug Plans. If prescription drug coverage is through the medical plan: Coinsurance is 10% for NJ DIRECT10, Freedom10, NJ DIRECT15, and Freedom15; Coinsurance is 15% for NJ DIRECT1525, Freedom1525, NJ DIRECT2030, and Freedom2030; Coinsurance is 20% for NJ DIRECT2035 and Freedom2035. For High Deductible Health Plans, prescription drug coverage must be through the SHBP medical plan and are subject to the plan's deductible and coinsurance amounts.

³ For maintenance prescription drugs, mail order is mandatory under NJ DIRECT2035 and Aetna Freedom 2035.

⁴ You pay the the cost difference between the brand drug and the generic drug.