

Benefit	26 Liberty		26 CWA Unity Freedom	
	Tier 1	Tier 2 – Nationwide	In network	Out of network
Medical network	APCN+ Multi-Tier Open Access Aetna Select SM		Aetna Choice [®] POS II	
Deductible				
	Individual	None	\$1,500	\$110 ¹
	Family	None	\$3,000	\$220 ¹
Coinsurance		0%	20%	10%
Maximum out-of-pocket limit				
	Individual	\$2,500	\$4,500	\$8,480
	Family	\$5,000	\$9,000	\$16,960
Doctors' office visits: primary care physician selection not required				
Primary care office visit		\$5	\$20	\$15
Specialist office visit		\$20	\$35	\$30
Diagnostic procedures				
Freestanding lab		\$0	\$0	\$0
Freestanding radiology/ advanced imaging		\$0	\$0	\$50
Outpatient lab		\$20	20% after deductible	\$0
Outpatient radiology/ advanced imaging		\$20	20% after deductible	\$50
Hospital care				
Inpatient admission		\$150 per admission ²	20% after deductible ²	\$0 ²
Outpatient department services/surgery		\$150 ²	20% after deductible ²	\$0 ²
Emergency care				
Emergency room		\$100	\$100	\$150
Ambulance		\$0	\$0	10%
Urgent care		\$35	\$50	\$45
Other services				
Acupuncture		\$20	20% after deductible	\$30
Short-term therapies: Physical, occupational, speech, respiratory		\$20 office visit/\$20 outpatient facility	\$35 office visit/20% after deductible at outpatient facility	\$30
PT/OT/SP limits	30-visit maximum each per calendar year		Based on medical necessity	PT 20 visit maximum
Chiropractic care		\$20	\$35	\$30
Chiropractic limits	25-visit maximum per calendar year		30-visit maximum per calendar year	
Durable medical equipment		\$0	\$0	10%
Out-of-network reimbursement	No out-of-network coverage		175% of CMS	

¹Deductible applies to all services which do not apply a copay.

²Services performed at a hospital when not medically necessary will be covered at 50% after deductible in and out of network.

- INN cost = in-network cost
- Retiree plan options are available at [NJ.gov/treasury/pensions/hb-retired-shbp.shtml](https://www.nj.gov/treasury/pensions/hb-retired-shbp.shtml).
- This is not a complete list of covered services. Exclusions and limitations apply to some services. Visit [NJ.gov/treasury/pensions/member-guidebooks.shtml](https://www.nj.gov/treasury/pensions/member-guidebooks.shtml) for more information.

Benefit	26 Freedom		26 Freedom 15	
	In network	Out of network	In network	Out of network
Medical network	Aetna Choice® POS II		Aetna Choice® POS II	
Deductible				
Individual	\$110 ¹	\$750	\$110 ¹	\$750
Family	\$220 ¹	\$1,500	\$220 ¹	\$1,550
Coinsurance	10%	30%	10%	30%
Maximum out-of-pocket limit				
Individual	\$8,480	\$2,500	\$8,480	\$2,500
Family	\$16,960	\$6,000	\$16,960	\$6,000
Doctors' office visits: primary care physician selection not required				
Primary care office visit	\$15	30% after deductible	\$15	30% after deductible
Specialist office visit	\$30	30% after deductible	\$15	30% after deductible
Diagnostic procedures				
Freestanding lab	\$0	30% after deductible	\$0	30% after deductible
Freestanding radiology/ advanced imaging	\$50	30% after deductible	\$50	30% after deductible
Outpatient lab	\$0	30% after deductible	\$0	30% after deductible
Outpatient radiology/ advanced imaging	\$50	30% after deductible	\$50	30% after deductible
Hospital care				
Inpatient admission	\$0 ²	\$500/stay plus 30% after deductible ²	\$0 ²	\$200/stay plus 30% after deductible ²
Outpatient department services/surgery	\$0 ²	30% after deductible ²	\$0 ²	30% after deductible ²
Emergency care				
Emergency room	\$150	\$150	\$100	\$100
Ambulance	10%	30% after deductible	10%	30% after deductible
Urgent care	\$45	30% after deductible	\$15	30% after deductible
Other services				
Acupuncture	\$30	30% after deductible; lesser of \$60/visit or 75% of INN cost/visit	\$15	30% after deductible; lesser of \$60/visit or 75% of INN cost/visit
Short-term therapies: Physical, occupational, speech, respiratory	\$30	30% after deductible for speech and occupational therapy; lesser of \$52/visit or 75% of INN cost/visit for physical therapy	\$15	30% after deductible for speech and occupational therapy; lesser of \$52/visit or 75% of INN cost/visit for physical therapy
PT/OT/SP limits	Based on medical necessity	20 visit maximum	Based on medical necessity	PT 20 visit maximum
Chiropractic care	\$30	30% after deductible; lesser of \$35/visit or 75% of INN cost/visit	\$15	30% after deductible; lesser of \$35/visit or 75% of INN cost/visit
Chiropractic limits	30-visit maximum per calendar year		30-visit maximum per calendar year	
Durable medical equipment	10%	30% after deductible	10%	30% after deductible
Out-of-network reimbursement	175% of CMS		90% of FAIR Health national	

¹Deductible applies to all services which do not apply a copay.

²Services performed at a hospital when not medically necessary will be covered at 50% after deductible in and out of network.

• INN cost = in-network cost

Benefit	26 Freedom 1525		26 Freedom 2030	
	In network	Out of network	In network	Out of network
Medical network	Aetna Choice® POS II		Aetna Choice® POS II	
Deductible				
Individual	\$110 ¹	\$750	\$110 ¹	\$750
Family	\$220 ¹	\$1,500	\$220 ¹	\$1,500
Coinsurance	10% ²	30%	10%	30%
Maximum out-of-pocket limit				
Individual	\$8,480	\$2,500	\$8,480	\$5,000
Family	\$16,960	\$6,000	\$16,960	\$12,500
Doctors' office visits: primary care physician selection not required				
Primary care office visit	\$15	30% after deductible	\$20	30% after deductible
Specialist office visit	\$25	30% after deductible	\$30 adult/\$20 child	30% after deductible
Diagnostic procedures				
Freestanding lab	\$0	30% after deductible	\$0	30% after deductible
Freestanding radiology/ advanced imaging	\$50	30% after deductible	\$50	30% after deductible
Outpatient lab	\$0	30% after deductible	\$0	30% after deductible
Outpatient radiology/ advanced imaging	\$50	30% after deductible	\$50	30% after deductible
Hospital care				
Inpatient admission	\$0 ²	\$200/stay plus 30% after deductible ²	\$0 ²	\$500/stay plus 30% after deductible ²
Outpatient department services/surgery	\$0 ²	30% after deductible ²	\$0 ²	30% after deductible ²
Emergency care				
Emergency room	\$100	\$100	\$125	\$125
Ambulance	10%	30% after deductible	10%	30% after deductible
Urgent care	\$25	30% after deductible	\$30 adult/\$20 child	30% after deductible
Other services				
Acupuncture	\$25	30% after deductible; lesser of \$60/visit or 75% of INN cost/visit	\$30 adult/\$20 child	30% after deductible; lesser of \$60/visit or 75% of INN cost/visit
Short-term therapies: Physical, occupational, speech, respiratory	\$25	30% after deductible for speech and occupational therapy; lesser of \$52/visit or 75% of INN cost/visit for physical therapy	\$30 adult/\$20 child	30% after deductible for speech and occupational therapy; lesser of \$52/visit or 75% of INN cost/visit for physical therapy
PT/OT/SP limits	Based on medical necessity	PT 20 visit maximum	Based on medical necessity	PT 20 visit maximum
Chiropractic care	\$25	30% after deductible; lesser of \$35/visit or 75% of INN cost/visit	\$30 adult/\$20 child	30% after deductible; lesser of \$35/visit or 75% of INN cost/visit
Chiropractic limits	30-visit maximum per calendar year		30-visit maximum per calendar year	
Durable medical equipment	10%	30% after deductible	10%	30% after deductible
Out-of-network reimbursement	90% of FAIR Health national		90% of FAIR Health national	

¹Deductible applies to all services which do not apply a copay.

²Services performed at a hospital when not medically necessary will be covered at 50% after deductible in and out of network.

• INN cost = in-network cost

Benefit	26 Freedom 2035		26 Freedom HDLow	
	In network	Out of network	In network	Out of network
Medical network	Aetna Choice® POS II		Aetna Choice® POS II	
Deductible				
Individual	\$200 ¹	\$800	\$1,700*	\$1,700*
Family	\$500 ¹	\$2,000	\$3,400*	\$3,400*
Coinsurance	20%	40%	20%	40%
Maximum out-of-pocket limit				
Individual	\$8,840	\$6,500	\$2,700	\$3,700
Family	\$16,960	\$13,000	\$5,400	\$7,400
Doctors' office visits: primary care physician selection not required				
Primary care office visit	\$20	40% after deductible	20% after deductible	40% after deductible
Specialist office visit	\$35	40% after deductible	20% after deductible	40% after deductible
Diagnostic procedures				
Freestanding lab	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Freestanding radiology/ advanced imaging	\$50	40% after deductible	20% after deductible	40% after deductible
Outpatient lab	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient radiology/ advanced imaging	\$50	40% after deductible	20% after deductible	40% after deductible
Hospital care				
Inpatient admission	20% after deductible ²	\$600/stay plus 40% after deductible ²	20% after deductible ²	40% after deductible ²
Outpatient department services/surgery	20% after deductible ²	40% after deductible ²	20% after deductible ²	40% after deductible ²
Emergency care				
Emergency room	\$300	\$300	20% after deductible	40% after deductible
Ambulance	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Urgent care	\$35	40% after deductible	20% after deductible	40% after deductible
Other services				
Acupuncture	\$35	40% after deductible; lesser of \$60/visit or 75% of INN cost/visit	20% after deductible	40% after deductible; lesser of \$60/visit or 75% of INN cost/visit
Short-term therapies: Physical, occupational, speech, respiratory	\$35	40% after deductible for speech and occupational therapy; lesser of \$52/visit or 75% of INN cost/visit for physical therapy	20% after deductible	40% after deductible for speech and occupational therapy; lesser of \$52/visit or 75% of INN cost/visit for physical therapy
PT/OT/SP limits	Based on medical necessity	PT 20 visit maximum	Based on medical necessity	PT 20 visit maximum
Chiropractic care	\$35	40% after deductible; lesser of \$35/visit or 75% of INN cost/visit	20% after deductible	40% after deductible; lesser of \$35/visit or 75% of INN cost/visit
Chiropractic limits	30-visit maximum per calendar year		30-visit maximum per calendar year	
Durable medical equipment	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Out-of-network reimbursement	90% of FAIR Health national		90% of FAIR Health national	

*In- and out-of-network deductible combined; includes eligible prescription drug cost-shares.

¹Deductible applies to all services which do not apply a copay.

²Services performed at a hospital when not medically necessary will be covered at 50% after deductible in and out of network.

• INN cost = in-network cost

Benefit	26 Freedom HDHigh		26 HMO
	In network	Out of network	In network
Medical network	Aetna Choice® POS II		Aetna SelectSM
Deductible			
Individual	\$4,200*	\$4,200*	None
Family	\$8,400*	\$8,400*	None
Coinsurance	20%	40%	0%
Maximum out-of-pocket limit			
Individual	\$5,200	\$6,200	\$8,480
Family	\$10,400	\$12,400	\$16,960
Doctors' office visits: primary care physician selection not required			Required
Primary care office visit	20% after deductible	40% after deductible	\$15
Specialist office visit	20% after deductible	40% after deductible	\$30
Diagnostic procedures			
Freestanding lab/radiology/advanced imaging	20% after deductible	40% after deductible	\$0
Outpatient lab/radiology/advanced imaging	20% after deductible	40% after deductible	\$0
Hospital care			
Inpatient admission	20% after deductible ¹	40% after deductible ¹	\$0 ¹
Outpatient department services/surgery	20% after deductible ¹	40% after deductible ¹	\$0 ¹
Emergency care			
Emergency room	20% after deductible	40% after deductible	\$100
Ambulance	20% after deductible	40% after deductible	\$0
Urgent care	20% after deductible	40% after deductible	\$45
Other services			
Acupuncture	20% after deductible	40% after deductible; lesser of \$60/visit or 75% of INN cost/visit	Not covered
Short-term therapies: Physical, occupational, speech, respiratory	20% after deductible	40% after deductible for speech and occupational therapy; lesser of \$52/ visit or 75% of INN cost/visit for physical therapy	\$30
PT/OT/SP limits	Based on medical necessity	PT 20 visit maximum	60-visit maximum per calendar year
Chiropractic care	20% after deductible	40% after deductible; lesser of \$35/visit or 75% of INN cost/visit	\$30
Chiropractic limits	30-visit maximum per calendar year		PT 20 visit maximum
Durable medical equipment	20% after deductible	40% after deductible	\$100 deductible
Out-of-network reimbursement	90% of FAIR Health national		No out-of-network coverage

*In- and out-of-network deductible combined; includes eligible prescription drug cost-shares.

¹Services performed at a hospital when not medically necessary will be covered at 50% after deductible in and out of network.