

**LOCAL GOVERNMENT RETIRED GROUP — SHBP MEDICAL PLAN DESIGN — 2017**

HR-0899-0217

	<b>Aetna Freedom 10 NJ DIRECT10</b>	<b>Aetna Freedom 15 NJ DIRECT15</b>	<b>Aetna Freedom 1525* NJ DIRECT1525</b>	<b>Aetna Freedom 2030* NJ DIRECT2030</b>	<b>Aetna HMO Horizon HMO<sup>1</sup></b>	<b>Aetna HMO1525 Horizon HMO1525<sup>1</sup></b>	<b>Aetna HMO2030* Horizon HMO2030<sup>1</sup></b>	<b>Aetna Value HD4000** NJ DIRECT HD4000**</b>
<b>Medical Cost Sharing</b>								
Primary Care Copayment	\$10	\$15	\$15	\$20	\$10	\$15	\$20	
Specialist Care Copayment	\$10	\$15	\$25	\$30/adult \$20/child***	\$10	\$25	\$30/adult \$20/child***	
Emergency Room Copayment	\$75	\$100	\$100	\$125	\$85	\$100	\$125	
In-Network Deductible (Individual/Family)								\$4,000/\$8,000
In-Network Coinsurance <sup>2</sup>	10%	10%	10%	10%				20% after deductible
In-Network Coinsurance Maximum (Individual/Family)		\$400/\$1,000	\$400/\$1,000	\$800/\$2,000				\$1,000/\$2,000
In-Network Out-of-Pocket Maximum (Individual/Family)	\$400/\$1,000	\$5,799/\$11,598	\$5,799/\$11,598	\$5,799/\$11,598	\$5,799/\$11,598	\$5,799/\$11,598	\$5,799/\$11,598	\$5,000/\$10,000
Out-of-Network Deductible (Individual/Family)	\$100/\$250	\$100/\$250	\$100/\$250	\$200/\$500				See In-Network Deductible <sup>3</sup>
Out-of-Network Coinsurance <sup>4</sup>	20%	30%	30%	30%				40%
Out-of-Network Out-of-Pocket Maximum (Individual/Family)	\$2,000/\$5,000	\$2,000/\$5,000	\$2,000/\$5,000	\$5,000/\$12,500				\$6,000/\$12,000
Out-of-Network Inpatient Hospital Deductible	\$200/stay	\$200/stay	\$200/stay	\$500/stay				
<b>Prescription Drug Copayments</b>								
Retail: Generic Brand Copayments	\$10.00	\$10.00	\$7.00	\$3.00	\$6.00	\$7.00	\$3.00	Subject to deductible and coinsurance
Retail: Preferred Brand Copayments	\$22.00	\$22.00	\$16.00	\$18.00	\$12.00	\$16.00	\$18.00	
Retail: Non-Preferred Brand Copayments	\$44.00	\$44.00	\$35.00	\$46.00	\$24.00	\$35.00	\$46.00	
Retail: Brand w/Generic Equivalent	member pays difference <sup>6</sup>	member pays difference <sup>6</sup>	member pays difference <sup>6</sup>	member pays difference <sup>6</sup>	member pays difference <sup>6</sup>	member pays difference <sup>6</sup>	member pays difference <sup>6</sup>	
Mail: Generic Brand Copayments	\$5.00	\$5.00	\$5.00	\$5.00	\$5.00	\$5.00	\$5.00	
Mail: Preferred Brand Copayments	\$33.00	\$33.00	\$40.00	\$36.00	\$18.00	\$40.00	\$36.00	
Mail: Non-Preferred Brand Copayments	\$55.00	\$55.00	\$88.00	\$92.00	\$30.00	\$88.00	\$92.00	
Mail: Brand w/Generic Equivalent	member pays difference <sup>6</sup>	member pays difference <sup>6</sup>	member pays difference <sup>6</sup>	member pays difference <sup>6</sup>	member pays difference <sup>6</sup>	member pays difference <sup>6</sup>	member pays difference <sup>6</sup>	
Prescription Drug Annual Out-of-Pocket Maximum <sup>5</sup>	\$1,351.00	\$1,351.00	\$1,351.00	\$1,351.00	\$1,351.00	\$1,351.00	\$1,351.00	

\* Medicare eligible retirees cannot enroll in the Aetna Freedom 1525, Aetna Freedom2030, or Aetna HMO2030 plans.

\*\*HD = High Deductible Health Plan (*Medicare-eligible retirees cannot enroll in the HD plans*).

\*\*\* Age 26 and under.

<sup>1</sup> Service areas for Horizon HMO plans are limited to New Jersey, New Castle County in Delaware, and bordering counties of Pennsylvania and New York.

<sup>2</sup> On select services.

<sup>3</sup> Out-of-Network Deductible is combined with In-Network Deductible.

<sup>4</sup> After deductible.

<sup>5</sup> Maximum out-of-pocket on prescription drugs per person per calendar year.

<sup>6</sup> Non-Medicare eligible retirees pay the applicable generic copayment as listed above, plus the cost difference between the brand drug and the generic drug.

**NOTE:** Medicare enrollees can review the Medicare Advantage plan designs at Aetna's Web site: [www.aetnastatenj.com](http://www.aetnastatenj.com)

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