

New Jersey School Employees' Health Benefits Program

Education Active Employees – 2019 Plans at a Glance*

| PLAN NAME > | HMO PLANS | | | | HDHP PLANS | | PPO PLANS | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|-----------------------------------------|-------------------------------------|---------------------------------------------------|-------------------------------------|---------------------------------------------------|-------------------------------------|---------------------------------------------------|-------------------------------------|---------------------------------------------------|--------------------------------------|---------------------------------------------------|--------------------------------------|
| | Aetna HMO | Aetna HMO 1525 | Aetna HMO 2030 | Aetna HMO 2035 | Aetna Value HD1500††† | | Aetna FREEDOM 10 | | Aetna FREEDOM 15 | | Aetna FREEDOM 1525 | | Aetna FREEDOM 2030 | | Aetna FREEDOM 2035 | |
| | | | | | In-network | Out-of-network | In-network | Out-of-network | In-network | Out-of-network | In-network | Out-of-network | In-network | Out-of-network | In-network | Out-of-network |
| Deductible | \$0 | \$0 | \$0 | \$200 Individual / \$500 Family | \$1,500 Individual / \$3,000 Family | \$1,500 Individual / \$3,000 Family | N/A | \$100 Individual / \$250 Family | N/A | \$100 Individual / \$250 Family | N/A | \$100 Individual / \$250 Family | N/A | \$200 Individual / \$500 Family | \$200 Individual / \$500 Family | \$800 Individual / \$2,000 Family |
| Out-of-Pocket Maximum | \$6,320 Individual / \$12,640 Family | \$6,320 Individual / \$12,640 Family | \$6,320 Individual / \$12,640 Family | \$6,320 Individual / \$12,640 Family | \$2,500 Individual / \$5,000 Family | \$3,500 Individual / \$7,000 Family | \$400 Individual / \$1,000 Family | \$2,000 Individual / \$5,000 Family | \$6,320 Individual / \$12,640 Family | \$2,000 Individual / \$5,000 Family | \$6,320 Individual / \$12,640 Family | \$2,000 Individual / \$5,000 Family | \$6,320 Individual / \$12,640 Family | \$5,000 Individual / \$12,500 Family | \$6,320 Individual / \$12,640 Family | \$6,500 Individual / \$13,000 Family |
| | Out-of-Pocket Maximum does not include pharmacy†† | | | | Out-of-Pocket Maximum includes pharmacy | | Out-of-Pocket Maximum does not include pharmacy†† | | Out-of-Pocket Maximum does not include pharmacy†† | | Out-of-Pocket Maximum does not include pharmacy†† | | Out-of-Pocket Maximum does not include pharmacy†† | | Out-of-Pocket Maximum does not include pharmacy†† | |
| Coinsurance Maximum | N/A | N/A | N/A | \$2,000 Individual / \$5,000 Family | \$1,000 Individual / \$2,000 Family | N/A | N/A | N/A | \$400 Individual / \$1,000 Family | N/A | \$400 Individual / \$1,000 Family | N/A | \$800 Individual / \$2,000 Family | N/A | \$2,000 Individual / \$5,000 Family | N/A |
| Preventive Care (Routine checkups, well-child exams, mammograms, prostate [DRE, PSAT] exams, colorectal cancer screening) | covered at 100% | covered at 100% | covered at 100% | covered at 100% | covered at 100% | not covered** | covered at 100% | not covered** | covered at 100% | not covered** | covered at 100% | not covered** | covered at 100% | not covered** | covered at 100% | not covered** |
| PCP or Primary Doctor Office Visit | \$10 | \$15 | \$20 | \$20 | 20% after deductible | 40% after deductible | \$10 | 20% after deductible | \$15 | 30% after deductible | \$15 | 30% after deductible | \$20 | 30% after deductible | \$20 | 40% after deductible |
| Specialist Office Visit | \$10 | \$25 | \$30 adults / \$20 children | \$35 | 20% after deductible | 40% after deductible | \$10 | 20% after deductible | \$15 | 30% after deductible | \$25 | 30% after deductible | \$30 adults / \$20 children | 30% after deductible | \$35 | 40% after deductible |
| Chiropractic Care (HMO – Limit to 20 visits per calendar year) (Value/Freedom – Limit to 30 visits per calendar year) | \$10 | \$25 | \$30 adults / \$20 children | \$35 | 20% after deductible | 40% after deductible | \$10 | 20% after deductible | \$15 | 30% after deductible | \$25 | 30% after deductible | \$30 adults / \$20 children | 30% after deductible | \$35 | 40% after deductible |
| Routine eye exams | \$10 | \$25 | \$30 adults / \$20 children | \$35 | 20% after deductible | not covered | \$10 | not covered | \$15 | not covered | \$25 | not covered | \$30 adults / \$20 children | not covered | \$35 | not covered |
| Diagnostic (Labs and X-rays) | \$0 | \$0 | \$0 | 20% after deductible | 20% after deductible | 40% after deductible | \$0 | 20% after deductible | \$0 | 30% after deductible | \$0 | 30% after deductible | \$0 | 30% after deductible | 20% after deductible | 40% after deductible |
| Emergency Room (Covered for true medical emergencies only) | \$35 | \$75 | \$125 | \$300 | 20% after deductible | 20% after deductible | \$25 | \$25 | \$50 | \$50 | \$75 | \$75 | \$125 | \$125 | \$300 | \$300 |
| Urgent Care Center (Not covered for non-urgent use of urgent care center) | \$10 | \$25 | \$30 adults / \$20 children | \$35 | 20% after deductible | 40% after deductible | \$10 | 20% after deductible | \$15 | 30% after deductible | \$25 | 30% after deductible | \$30 adults / \$20 children | 30% after deductible | \$35 | 40% after deductible |
| Ambulance | \$0 | \$0 | \$0 | 20% after deductible | 20% after deductible | 40% after deductible | 10% | 20% after deductible | 10% | 30% after deductible | 10% | 30% after deductible | 10% | 30% after deductible | 20% after deductible | 40% after deductible |
| Durable Medical Equipment | 100% after \$100 deductible | 100% after \$100 deductible | 100% after \$100 deductible | 20% after deductible | 20% after deductible | 40% after deductible | 10% | 20% after deductible | 10% | 30% after deductible | 10% | 30% after deductible | 10% | 30% after deductible | 20% after deductible | 40% after deductible |
| Hospital Care (Inpatient, outpatient, maternity) | \$0 | \$0 | \$0 | 20% after deductible | 20% after deductible | 40% after deductible | \$0 | 20% after deductible | \$0 | 30% after deductible | \$0 | \$200/stay 30% after deductible | \$0 | \$500/stay 30% after deductible | 20% after deductible | \$600/stay 40% after deductible |
| Mental health service Inpatient | \$0 | \$0 | \$0 | 20% after deductible | 20% after deductible | 40% after deductible | \$0 | 20% after deductible | \$0 | 30% after deductible | \$0 | \$200/stay 30% after deductible | \$0 | \$500/stay 30% after deductible | 20% after deductible | \$600/stay 40% after deductible |
| Outpatient | \$10 | \$25 | \$30 adults / \$20 children | \$35 | 20% after deductible | 40% after deductible | \$10 | 20% after deductible | \$15 | 30% after deductible | \$25 | 30% after deductible | \$30 adults / \$20 children | 30% after deductible | \$35 | 40% after deductible |

* This is not a complete list of all covered services. Exclusions and limitations apply to some services. For example, preventive care services may be limited to one per year.

** Annual Ob/Gyn checkup, annual mammography, annual PAP smear, and well-child immunizations up to 12 months old covered at standard out-of-network coinsurance level for the plan after applicable deductibles.

†† Pharmacy out-of-pocket maximum for the Aetna Liberty, Aetna HMO and Aetna Freedom plans is \$1,470 Individual / \$2,940 Family.

††† Part-time employees are not eligible for the Aetna Value HD1500 plan



Health insurance plans are offered, underwritten and/or administered by Aetna Life Insurance Company (Aetna).

For the latest information, including plan details and benefit coverage, visit the Aetna Member Handbook on the Division of Pensions and Benefits website.

AetnaStateNJ.com

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