New Jersey State Health Benefits Program

Local Government Active Employees – 2019 Plans at a Glance*

	TIERED PLANS		HMO PLANS	HDHP PLANS			
PLAN NAME >	Aetna Liberty Plan		Aetna HMO	Aetna Value HD1500†††		Aetna Value HD4000	
	Tier 1 (NJ, PA, NY)	Tier 2 (Nationwide)		In-network	Out-of-network	In-network	Out-of-network
Deductible	$0	$1,500	$0	$1,500 Individual / $3,000 Family	$1,500 Individual / $3,000 Family	$4,000 Individual / $8,000 Family	$4,000 Individual / $8,000 Family
Out-of-Pocket Maximum	$2,500 Individual / $5,000 Family	$4,500 Individual / $9,000 Family	$6,320 Individual / $12,640 Family	$2,500 Individual / $5,000 Family	$3,500 Individual / $7,000 Family	$5,000 Individual / $10,000 Family†	$6,000 Individual / $12,000 Family
	Out-of-Pocket Maximum does not include pharmacy††		Out-of-Pocket Maximum does not include pharmacy††	Out-of-Pocket Maximum includes pharmacy		Out-of-Pocket Maximum includes pharmacy	
Coinsurance Maximum	N/A	N/A	N/A	$1,000 Individual / $2,000 Family	N/A	$1,000 Individual / $2,000 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%	not covered**	covered at 100%	not covered**
PCP or Primary Doctor Office Visit	$5	$20	$10	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Specialist Office Visit	$15	$30	$10	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Routine eye exams	$15	$30	$10	20% after deductible	not covered	20% after deductible	not covered
Diagnostic Labs	Quest – $0 Hospital/ Outpatient – $15	Quest – $0 Hospital/ Outpatient – 20% after deductible	$0	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Emergency Room (Covered for true medical emergencies only)	$100	$100	$85	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Urgent Care Center (Not covered for non-urgent use of urgent care center)	$15	$30	$10	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Ambulance	$0	$0	$0	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Durable Medical Equipment	$0	20% after deductible	100% after $100 deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Hospital Care (Inpatient, maternity)	Inpatient - $150 per admission Maternity Inpatient - $0	20% after deductible	$0	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Mental health service Inpatient	$0	20% after deductible	$0	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient (Office Visit)	$15	$30	$10	20% after deductible	40% after deductible	20% after deductible	40% after deductible

	PPO PLANS									
PLAN NAME >	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
Deductible	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	$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 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	$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%	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	20% after deductible	$15	30% after deductible	$15	30% after deductible	$20	30% after deductible	$20	40% after deductible
Specialist Office Visit	$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	not covered	$15	not covered	$25	not covered	$30 adults / $20 children	not covered	$35	not covered
Diagnostic Labs	$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)	$75	$75	$100	$100	$100	$100	$125	$125	$300	$300
Urgent Care Center (Not covered for non-urgent use of urgent care center)	$10	20% after deductible	$15	30% after deductible	$25	30% after deductible	$30 adults / $20 children	30% after deductible	$35	40% after deductible
Ambulance	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	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, maternity)	$0	$200/stay 20% after deductible	$0	$200/stay 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	$200/stay 20% after deductible	$0	$200/stay 30% after deductible	$0	$200/stay 30% after deductible	$0	$500/stay 30% after deductible	20% after deductible	$600/stay 40% after deductible
Outpatient (Office Visit)	$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.

† The Out-of Pocket Maximum for a family enrolled in the Aetna Value HD4000 plan is $10,000. If one family member reaches $6,850 in out-of-pocket costs during a calendar year, that family member will no longer have to pay their member cost share for the duration of the calendar year. The other members of the family will be responsible for their member cost share until the $10,000 family out-of-pocket maximum is met.

†† 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. Members who elect a PayFlex Health Savings Account (HSA) are eligible for a $300 employer contribution into their HSA annually.

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.

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