STATE RETIRED GROUP
MEDICAL PLAN DESIGN - PLAN YEAR 2024

HR-0898-0424

Aetna Plan Options (Available July 1, 2024)	Freedom*	Freedom10*	Freedom15*	Freedom1525	Freedom2030	Aetna HMO[1]	Aetna HMO1525[1]	Aetna HMO2030[1]	Aetna Liberty Plus*		Freedom HDLow*	Freedom HDHigh*
Horizon Plan Options	**NJ DIRECT***	**NJ DIRECT10***	**NJ DIRECT15***	**NJ DIRECT1525**	**NJ DIRECT2030**	**Horizon HMO[1]**	**Horizon HMO1525[1]**	**Horizon HMO2030[1]**	**Horizon OMNIA***		**NJ DIRECT HDLow***	**NJ DIRECT HDHigh***
Medical Cost Sharing									**TIER 1**	**TIER 2**		
Primary Care Copayment	$15	$10	$15	$15	$20	$10	$15	$20	$5	$20	20% coinsurance after deductible	20% coinsurance after deductible
Specialist Care Copayment	$15	$10	$15	$25	$30/adult $20/child**	$10	$25	$30/adult $20/child**	$15	$30	20% coinsurance after deductible	20% coinsurance after deductible
Urgent Care Copayment	$15	$10	$15	$25	$30/adult $20/child**	$10	$25	$30/adult $20/child**	$15	$30	20% coinsurance after deductible	20% coinsurance after deductible
Emergency Room Copayment	$150	$75	$100	$100	$125	$85	$100	$125	$100	$100	20% coinsurance after deductible	20% coinsurance after deductible
In-Network Deductible (Individual/Family)	None	None	None	None	None	None	None	None	None	$1,500/$3,000	$1,600/$3,200	$4,100/$8,200
In-Network Coinsurance[2]	10%	10%	10%	10%	10%	10%	10%	10%	None	20% after deductible	20%	20%
In-Network Coinsurance Maximum (Individual/Family)	$800/$2,000	None	$400/$1,000	$400/$1,000	$800/$2,000	None	None	None	None	None	None	None
In-Network Out-of-Pocket Maximum (Individual/Family)	$8,099/$16,198	$400/$1,000	$8,099/$16,198	$8,099/$16,198	$8,099/$16,198	$8,099/$16,198	$8,099/$16,198	$8,099/$16,198	$2,500/ $5,000	$4,500/ $9,000	$2,600/$5,200	$5,100/$10,200
Out-of-Network Deductible (Individual/Family)	$400/$1,000	$100/$250	$100/$250	$100/$250	$200/$500						See In-Network Deductible[3]	See In-Network Deductible[3]
Out-of-Network Coinsurance[4]	30%	20%	30%	30%	30%						40%	40%
Out-of-Network Out-of-Pocket Maximum (Individual/Family)	$2,000/$5,000	$2,000/$5,000	$2,000/$5,000	$2,000/$5,000	$5,000/$12,500						$3,600/$7,200	$6,100/$12,200
Out-of-Network Inpatient Hospital Deductible	$500/stay	$200/stay	$200/stay	$200/stay	$500/stay						None	None

* **Medicare-eligible retirees and/or Medicare-eligible spouses of retirees will be enrolled in a corresponding plan. Please view corresponding Medicare Retiree chart for more information.**

** **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. Aetna HMO plans are not limited to this service area and utilize Aetna's nationwide Aetna Select network.

2 On select services. Please see plan guidebook.

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

4 After Deductible.

Note: Medicare enrollees can review the Medicare Advantage plan designs at Aetna's website: ***www.aetnastatenj.com*** All plans available to Medicare eligible members can be found on our website via the corresponding Medicare plan comparison chart.

STATE RETIRED GROUP
PRESCRIPTION PLAN DESIGN - PLAN YEAR 2024

HR-0898-0424

Aetna Plan Options (Available July 1, 2024)	Freedom	Freedom10	Freedom15	Freedom1525	Freedom2030	Aetna HMO[1]	Aetna HMO1525[1]	Aetna HMO2030[1]	Aetna Liberty Plus	Freedom HDLow	Freedom HDHigh
Horizon Plan Options	**NJ DIRECT**	**NJ DIRECT10**	**NJ DIRECT15**	**NJ DIRECT1525**	**NJ DIRECT2030**	**Horizon HMO[1]**	**Horizon HMO1525[1]**	**Horizon HMO2030[1]**	**Horizon OMNIA**	**NJ DIRECT HDLow**	**NJ DIRECT HDHigh**
Prescription Drug Copayments											
Retail: Generic Copayments	$7	$10	$10	$7	$3	$6	$7	$3	$7	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Retail: Preferred Brand Copayments	$16	$22	$22	$16	$18	$12	$16	$18	$16		
Retail: Non-Preferred Brand Copayments	$35	$44	$44	$35	$46	$24	$35	$46	$35		
Retail: Brand w/ Generic Equivalent	Member pays difference[2]	Member pays difference[2]	Member pays difference[2]	Member pays difference[2]	Member pays difference[2]	Member pays difference[2]	Member pays difference[2]	Member pays difference[2]	Member pays difference[2]		
Mail: Generic Copayments	$18	$5	$5	$5	$5	$5	$5	$5	$18		
Mail: Preferred Brand Copayments	$40	$28	$28	$40	$36	$18	$40	$36	$40		
Mail: Non-Preferred Brand Copayments	$88	$55	$55	$88	$92	$30	$88	$92	$88		
Mail: Brand w/ Generic Equivalent	Member pays difference[2]	Member pays difference[2]	Member pays difference[2]	Member pays difference[2]	Member pays difference[2]	Member pays difference[2]	Member pays difference[2]	Member pays difference[2]	Member pays difference[2]		
Prescription Drug annual Out-of-Pocket Maximum (Individual/Family)	$1,351/$2,702	$1,351/$2,702	$1,351/$2,702	$1,351/$2,702	$1,351/$2,702	$1,351/$2,702	$1,351/$2,702	$1,351/$2,702	$1,351/$2,702		

[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. Aetna HMO plans are not limited to this service area and utilize Aetna's nationwide Aetna Select network.

[2] You pay the cost difference between the brand drug and the generic drug.

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This is a summary and not intended to provide all information. Although every attempt at accuracy is made, it cannot be guaranteed.