

State Health Benefits Program (SHBP)
MEDICAL PLAN DESIGN - PLAN YEAR 2022
MEDICARE ADVANTAGE AND MEDICARE SUPPLEMENTAL GROUP PLANS

	Aetna Medicare Advantage Plans ²				Horizon Medicare Supplemental Plans				
	Medicare Advantage PPO ESA 10 (Freedom 10)	Medicare Advantage PPO ESA 15 (Freedom 15)	Medicare Advantage Open Access HMO (HMO)	Medicare Advantage Open Access HMO 1525 (HMO 1525)	NJ DIRECT1525	NJ DIRECT2030	Horizon HMO	Horizon HMO1525	Horizon HMO2030
Medical Cost Sharing									
Primary Care Copayment	\$10	\$15	\$10	\$15	\$15	\$20	\$10	\$15	\$20
Specialist Care Copayment	\$10	\$15	\$10	\$25	\$25	\$30/\$20 (child)	\$10	\$25	\$30/\$20 (child)
Emergency Room Copayment	\$75	\$75	\$75	\$75	\$100	\$125	\$85	\$100	\$125
In-Network Deductible (Individual/Family)									
In-Network Overall Coinsurance					10% ³	10% ³	10% ³	10% ³	10% ³
In-Network Coinsurance Out-of-Pocket Maximum (Individual/Family) ¹					\$400/\$1,000	\$800/\$2,000			
Total In-Network Out-of-Pocket Maximum (Individual/Family)	\$400 per person	\$1,000 per person	\$2,500 per person	\$2,500 per person	\$7,349/\$14,698	\$7,349/\$14,698	\$7,349/\$14,698	\$7,349/\$14,698	\$7,349/\$14,698
Out-of-Network Deductible (Individual/Family)			Not covered	Not covered	\$100/\$250	\$200/\$500	Not covered	Not covered	Not covered
Out-of-Network Overall Coinsurance ¹			Not Covered	Not Covered	30%	30%	Not covered	Not covered	Not covered
Total Out-of-Network Out-of-Pocket Maximum (Individual/Family)	\$400 per person; Combined In- and Out-of-Network	\$1,000 per person; Combined In- and Out-of-Network	Not covered	Not covered	\$2,000/\$5,000	\$5,000/\$12,500	Not covered	Not covered	Not covered

¹ Coinsurance Out-of-Pocket Maximum applies on the applicable Horizon plans for in-network outpatient private duty nursing, in- or out-of-network ambulance, durable medical equipment and some prosthetic and orthotic services. ³ On Select Services.

² Medicare Advantage plans do not have In-Network and Out-of-Network differentiation. Medicare Advantage plans provide coverage at the same benefit level regardless of network status for visits to any provider that accepts Medicare.

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Prescription Drug Copayments¹									
Retail: Generic Copayments	\$10	\$10	\$6	\$7	\$7	\$3	\$6	\$7	\$3
Retail: Preferred Brand Copayments	\$22	\$22	\$12	\$16	\$16	\$18	\$12	\$16	\$18
Retail: Non-Preferred Brand Copayments	\$44	\$44	\$24	\$35	\$35	\$46	\$24	\$35	\$46
Mail: Generic Copayments ²	\$5	\$5	\$5	\$5	\$5	\$5	\$5	\$5	\$5
Mail: Preferred Brand Copayments ²	\$28	\$28	\$18	\$40	\$40	\$36	\$18	\$40	\$36
Mail: Non-Preferred Brand Copayments ²	\$55	\$55	\$30	\$88	\$88	\$92	\$30	\$88	\$92
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 Mail Copay amounts shown above are for 30 day prescriptions. Copays for 90-day prescriptions may differ.

² 30-day copays for Specialty Pharmacy in the Employer Group Waiver Plan (EGWP) range from \$1 for generic, \$6-\$13 for preferred brand, and \$10-\$30 for non-preferred brand depending on retiree plan option.