



**UNION NEGOTIATED PLANS  
MEDICAL PLAN DESIGN - PLAN YEAR 2021  
STATE ACTIVE GROUP**

HA-1059-0920

Explore Your Benefits

**HORIZON PLANS - MEDICAL COST SHARING**

	NJ DIRECT/ NJ DIRECT 2019*	Horizon HMO <sup>1</sup>	Horizon OMNIA		NJ DIRECT HD4000**	NJ DIRECT HD1500**
Medical Cost Sharing			TIER 1	TIER 2	20% coinsurance after deductible	20% coinsurance after deductible
Primary Care Copayment	\$15	\$15	\$5	\$20	20% coinsurance after deductible	20% coinsurance after deductible
Specialist Care Copayment	\$15	\$15	\$15	\$30	20% coinsurance after deductible	20% coinsurance after deductible
Emergency Room Copayment	\$150 <sup>9</sup>	\$100	\$100	\$100	20% coinsurance after deductible	20% coinsurance after deductible
In-Network Deductible	\$100 <sup>8</sup> (if hired after 7/1/19)	\$100 <sup>2</sup>	None	\$1,500 <sup>7</sup>	\$4,000 <sup>7</sup>	\$1,500 <sup>7</sup>
In-Network Coinsurance	10% <sup>2</sup>	10% <sup>2</sup>	None	20%	20% after deductible	20% after deductible
In-Network Coinsurance Maximum (Individual/Family)	\$800/\$2,000	None	None	None	None	None
In-Network Out-of-Pocket Maximum (Individual/Family)	\$6,840/\$13,680	\$6,840/\$13,680	\$2,500 <sup>7</sup>	\$4,500 <sup>7</sup>	\$5,000/\$10,000	\$2,500/\$5,000
Out-of-Network Deductible (Individual/Family)	\$400/\$1,000				See In-Network Deductible <sup>3</sup>	See In-Network Deductible <sup>3</sup>
Out-of-Network Coinsurance <sup>4</sup>	30%				40%	40%
Out-of-Network Out-of-Pocket Maximum (Individual/Family)	\$2,000/\$5,000				\$6,000/\$12,000	\$3,500/\$7,000
Out-of-Network Inpatient Hospital Deductible	\$500				None	None
Employer Health Savings Account Funding <sup>5</sup>						\$300
Out of Network Reimbursement Rate <sup>11</sup>	175% CMS Exceptions: Mental Health after OOP Max get 195% CMS (good through 7/1/2021) and Ob- stetrics at 195% <sup>10</sup> CMS until treatment completed				After deductible, 60% of reasonable and customary allowance	After deductible, 60% of reasonable and customary allowance

**Note:** NJ DIRECT members and spouses who participate in NJWELL and complete the necessary health screenings and activities can earn a financial reward of \$350 each.

\* **Members hired before July 1, 2019, will be enrolled in NJ DIRECT. Members hired after July 1, 2019, will be enrolled in NJ DIRECT 2019.**

\*\* **HD = High Deductible Health Plan**

<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> Health Savings Accounts can be used for qualified medical expenses without federal tax liability.

<sup>6</sup> Applies to services that do not require a copayment.

<sup>7</sup> Family amounts are 2 x per member amounts listed in table.

<sup>8</sup> \$100 in network deductible has exclusions: 2<sup>nd</sup> wellness visit, preventive, obstetrics, pediatrics, and any deductible applied to other services.

<sup>9</sup> \$50 for adults referred to the emergency room by their primary care physician and for pediatric (through age 19).

<sup>10</sup> If services started prior to July 1, 2019. If obstetric services started after July 1, 2019, reimbursement rate is 175%.

<sup>11</sup> All plans with out-of-network benefits have specified dollar limits for chiropractic, physical therapy, and acupuncture.



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<b>Prescription Drug Copayments</b>					
Retail: Generic Copayments	\$7	\$3	\$7	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Retail: Brand Copayments	\$16	\$10	\$16		
Retail: Brand w/Generic available Copayments <sup>2</sup>	Member pays difference <sup>2</sup>	Member pays difference <sup>2</sup>	Member pays difference <sup>2</sup>		
Mail: Generic Copayments	\$0	\$0	\$0		
Mail: Brand Copayments	\$40	\$15	\$40		
Mail: Brand w/Generic available Copayments <sup>2</sup>	Member pays difference <sup>2</sup>	Member pays difference <sup>2</sup>	Member pays difference <sup>2</sup>		
Prescription Drug annual Out-of-Pocket Maximum (Individual/Family)	\$1,710/\$3,420	\$1,710/\$3,420	\$1,710/\$3,420		

**Note:** Retail – 30 day supply. Mail – 90 day supply. Oral contraceptive coverage is available under the medical and prescription plans.

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<sup>2</sup> You pay the cost difference between the brand drug and the generic drug.

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