Get Covered NJ
New Jersey's Official Health Insurance Marketplace

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Compare Plans

	EXPENSE ESTIMATE LOW ($)	EXPENSE ESTIMATE LOW ($)	EXPENSE ESTIMATE LOW ($)
	MARKETPLACE PLAN	MARKETPLACE PLAN	MARKETPLACE PLAN
	United Healthcare	United Healthcare	AmeriHealth
	UHC Silver Advantage ($0...	**UHC Bronze Value ($0 Vir...**	**IHC Silver EPO AmeriHeal...**
	SILVER EPO	BRONZE EPO	SILVER EPO
	$961.85 /month	**$695.44 /month**	**$719.92 /month**
	after $866.00 savings	after $866.00 savings	after $866.00 savings
	ADD	ADD	ADD

Summary

Expense Estimate*	$14467.84	$12641.40	$11825.80
Plan Type *	EPO	EPO	EPO
HSA-compatible *	No	No	No

Doctors and Facilities

Dr. Mary Catherine Lare Student in an Organized Health Care Education/Training Program, Family Medicine Physician 973-379-2111 18 Lyons Rd Ste 101 Basking Ridge, NJ 07920	In-Network	In-Network	In-Network

Deductible & Out-of-Pocket (In Network)

Deductible	$2500 (Individual) $5000 (Family)	$3000 (Individual) $6000 (Family)	$2500 (Individual) $5000 (Family)
Separate Drug Deductible	Included in deductible	Included in deductible	$250 (Individual)
Out-of-Pocket max *	$9200 (Individual) $18400 (Family)	$9200 (Individual) $18400 (Family)	$9000 (Individual) $18000 (Family)

Doctor Visit

Primary Care Visit *	$20 Copay **Benefit Explanation** Cost sharing for Virtual Primary Care matches in-person office visit.	$50 Copay **Benefit Explanation** Cost sharing for Virtual Primary Care matches in-person office visit.	$25 Copay
Specialist Visit *	$75 Copay	$75 Copay after deductible	$60 Copay

Other Practitioner Office Visit (Nurse, Physician Assistant) *	40% Coinsurance after deductible	50% Coinsurance after deductible	$25 Copay **Benefit Explanation** Cost share may vary depending on place of service or network status of provider. **Limits & Exclusions** Care and/or treatment by a Christian Science practitioner or care by a family member
Preventive Care/Screening/Immunization *	No Charge	No Charge	No Charge **Benefit Explanation** Age and frequency schedules may apply. **Limits & Exclusions** Routine immunizations for the sole purpose of travel or as a requirement for a member's employment.

Tests

Laboratory Outpatient and Professional Services	$25 Copay after deductible	50% Coinsurance after deductible	No Charge
X-rays and Diagnostic Imaging	$35 Copay after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible
Imaging (CT/PET scans, MRIs)	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible

Drugs

Generic Drugs	$10 Copay **Benefit Explanation** Members can obtain a 1 month supply through network pharmacies or home delivery. Members also have the option to receive a 3 month supply through network pharmacy or home delivery. Other quantity limits may apply. Check the plan's Summary of Benefits or Prescription Drug List for more information. **Limits & Exclusions** 30 Days per Month	$25 Copay **Benefit Explanation** Members can obtain a 1 month supply through network pharmacies or home delivery. Members also have the option to receive a 3 month supply through network pharmacy or home delivery. Other quantity limits may apply. Check the plan's Summary of Benefits or Prescription Drug List for more information. **Limits & Exclusions** 30 Days per Month	$25 Copay **Limits & Exclusions** Drugs prescribed for cosmetic purposes; non-prescription drugs.
Preferred Brand Drugs	40% Coinsurance after deductible **Benefit Explanation** Members can obtain a 1 month supply through network pharmacies or home delivery. Members also have the option to receive a 3 month supply through network pharmacy or home delivery. Other quantity limits may apply. Check the plan's Summary of Benefits or Prescription Drug List for more information. **Limits & Exclusions** 30 Days per Month	40% Coinsurance after deductible **Benefit Explanation** Members can obtain a 1 month supply through network pharmacies or home delivery. Members also have the option to receive a 3 month supply through network pharmacy or home delivery. Other quantity limits may apply. Check the plan's Summary of Benefits or Prescription Drug List for more information. **Limits & Exclusions** 30 Days per Month	50% Coinsurance after deductible **Limits & Exclusions** Drugs prescribed for cosmetic purposes; non-prescription drugs.
Non-Preferred Brand Drugs	45% Coinsurance after deductible **Benefit Explanation** Members can obtain a 1 month supply through network pharmacies or home delivery. Members also have the option to receive a 3 month supply through network pharmacy or home delivery. Other quantity limits may apply. Check the plan's Summary of Benefits or Prescription Drug List for more information. **Limits & Exclusions** 30 Days per Month	45% Coinsurance after deductible **Benefit Explanation** Members can obtain a 1 month supply through network pharmacies or home delivery. Members also have the option to receive a 3 month supply through network pharmacy or home delivery. Other quantity limits may apply. Check the plan's Summary of Benefits or Prescription Drug List for more information. **Limits & Exclusions** 30 Days per Month	50% Coinsurance after deductible **Limits & Exclusions** Drugs prescribed for cosmetic purposes; non-prescription drugs.
Specialty drugs	50% Coinsurance after deductible **Benefit Explanation** Specialty medications are limited to a 1-month supply. Other quantity limits may apply. Check the plan's Summary of Benefits or Prescription Drug List for more information. **Limits & Exclusions** 30 Days per Month	50% Coinsurance after deductible **Benefit Explanation** Specialty medications are limited to a 1-month supply. Other quantity limits may apply. Check the plan's Summary of Benefits or Prescription Drug List for more information. **Limits & Exclusions** 30 Days per Month	50% Coinsurance after deductible **Limits & Exclusions** Drugs prescribed for cosmetic purposes; non-prescription drugs.

Outpatient

Outpatient Facility Fee	40% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible
Outpatient Surgery Physician/Surgical Services	40% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible **Limits & Exclusions** Local anesthesia billed separately when charges are included in surgery fee.

ER & Urgent Care

Emergency Room Services	$100 Copay with deductible 40% Coinsurance after deductible	$100 Copay with deductible 50% Coinsurance after deductible	20% Coinsurance after deductible
Emergency Transportation/Ambulance	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible **Limits & Exclusions** Chartered flights. Travel or communication expenses of patients, health care providers or family members. Services for ambulance transport from a hospital to another facility except when a member is transferred to another inpatient health care facility.
Urgent Care	$75 Copay **Benefit Explanation** $0 Virtual Urgent Care visits are available through vendor. See SBC for additional cost share details for in-person urgent care visits.	$75 Copay after deductible **Benefit Explanation** $0 Virtual Urgent Care visits are available through vendor. See SBC for additional cost share details for in-person urgent care visits.	20% Coinsurance after deductible

Hospital

Inpatient Hospital Services	40% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible
Inpatient Physician and Surgical Services	40% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible **Limits & Exclusions** Local anesthesia charges if billed separately when charges are included in the fee for the surgery.

Mental / Behavioral Health

Mental/Behavioral Health Outpatient Services	$75 Copay	$75 Copay after deductible	$60 Copay **Limits & Exclusions** Custodial care, education and training.
Mental/Behavioral Health Inpatient Services	40% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible
Substance Abuse Disorder Outpatient Services	$75 Copay	$75 Copay after deductible	$60 Copay **Benefit Explanation** Pre-authorization or Pre-Approval are not required for the first 180 days of inpatient and/or outpatient treatment during each Calendar Year but may be required for inpatient treatment for the balance of the Calendar Year. **Limits & Exclusions** Custodial care, education and training.
Substance Abuse Disorder Inpatient Services	40% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible **Benefit Explanation** Pre-authorization or Pre-Approval are not required for the first 180 days of inpatient and/or outpatient treatment during each Calendar Year but may be required for inpatient treatment for the balance of the Calendar Year.

Pregnancy

Prenatal and postnatal care	No Charge	No Charge	No Charge

Delivery and All Inpatient Services for Maternity Care	40% Coinsurance after deductible **Benefit Explanation** Childbirth/delivery professional services follow inpatient physician/surgeon fees.	50% Coinsurance after deductible **Benefit Explanation** Childbirth/delivery professional services follow inpatient physician/surgeon fees.	20% Coinsurance after deductible

Other Special Needs

Home Healthcare Services	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible **Benefit Explanation** Pre-approval required. Covers medically necessary and appropriate services in a written home health plan when certified as needed to avoid continuing hospitalization or confinement in a SNF. Services and supplies must be included in the written plan and furnished by a home health agency through recognized health care professionals. The covered person's practitioner must establish the written plan within 14 days after home health care starts and review it at least once every 60 days. Visit limitations for Home Health Care do not apply to NJ Individual Plans. **Limits & Exclusions** Services furnished to family members, other than the patient. Services and supplies not included in the home health care plan.
Outpatient Rehabilitation Services	40% Coinsurance after deductible **Benefit Explanation** Coverage for Physical Therapy and Occupational Therapy, combined, is limited to 30 visits per calendar year; coverage of cognitive rehabilitation therapy and speech therapy, combined, is limited to 30 visits per calendar year. **Limits & Exclusions** 30 Visit(s) per Year	50% Coinsurance after deductible **Benefit Explanation** Coverage for Physical Therapy and Occupational Therapy, combined, is limited to 30 visits per calendar year; coverage of cognitive rehabilitation therapy and speech therapy, combined, is limited to 30 visits per calendar year. **Limits & Exclusions** 30 Visit(s) per Year	$60 Copay **Benefit Explanation** Coverage for Physical Therapy and Occupational Therapy, is limited to 30 visits each per calendar year; coverage of cognitive rehabilitation therapy and speech therapy, is limited to 30 visits each per calendar year. **Limits & Exclusions** 30 Visit(s) per Year
Habilitation Services	40% Coinsurance after deductible **Benefit Explanation** As required by MHPAEA, the 30 visit limit does not apply to physical therapy, speech therapy, occupational therapy or applied behavior analysis provided to a patient who has autism. **Limits & Exclusions** 30 Visit(s) per Year	50% Coinsurance after deductible **Benefit Explanation** As required by MHPAEA, the 30 visit limit does not apply to physical therapy, speech therapy, occupational therapy or applied behavior analysis provided to a patient who has autism. **Limits & Exclusions** 30 Visit(s) per Year	$60 Copay **Benefit Explanation** As required by MHPAEA, the 30 visit limit does not apply to speech, physical and occupational therapies covered under the Diagnosis and Treatment of Autism and Other Developmental Disabilities. Coverage for Physical Therapy and Occupational Therapy, is limited to 30 visits each per calendar year; coverage of cognitive rehabilitation therapy and speech therapy, is limited to 30 visits each per calendar year. **Limits & Exclusions** 30 Visit(s) per Year
Skilled Nursing Facility	40% Coinsurance after deductible **Benefit Explanation** Referred to as Extended Care Center	50% Coinsurance after deductible **Benefit Explanation** Referred to as Extended Care Center	20% Coinsurance after deductible **Benefit Explanation** Referred to as Extended Care Center.
Durable Medical Equipment	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible
Hospice Services	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible
Acupuncture	Not Covered **Benefit Explanation** Care or treatment by means of acupuncture is excluded except when used as a substitute for other forms of anesthesia.	Not Covered **Benefit Explanation** Care or treatment by means of acupuncture is excluded except when used as a substitute for other forms of anesthesia.	Not Covered
Rehabilitative Speech Therapy	40% Coinsurance after deductible **Limits & Exclusions** 30 Visit(s) per Year	50% Coinsurance after deductible **Limits & Exclusions** 30 Visit(s) per Year	$60 Copay **Benefit Explanation** 30 visits each for Speech and Cognitive therapy. **Limits & Exclusions** 30 Visit(s) per Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	40% Coinsurance after deductible **Benefit Explanation** Coverage for occupational therapy and physical therapy combined is limited to 30 visits per Calendar	50% Coinsurance after deductible **Benefit Explanation** Coverage for occupational therapy and physical therapy combined is limited to 30 visits per Calendar	$60 Copay **Benefit Explanation** 30 visits each for Physical and Occupational therapy. **Limits & Exclusions** 30 Visit(s) per Year

	Year. **Limits & Exclusions** 30 Visit(s) per Year	Year. **Limits & Exclusions** 30 Visit(s) per Year	
Well Baby Visits and Care	No Charge **Benefit Explanation** Under preventive care	No Charge **Benefit Explanation** Under preventive care	No Charge **Benefit Explanation** Under preventive care.
Allergy Testing	$75 Copay **Benefit Explanation** The policy covers non-surgical care and treatment which includes diagnostic services. Allergy testing is covered as a diagnostic service.	$75 Copay after deductible **Benefit Explanation** The policy covers non-surgical care and treatment which includes diagnostic services. Allergy testing is covered as a diagnostic service.	$60 Copay **Benefit Explanation** The policy covers non-surgical care and treatment which includes diagnostic services. Allergy testing is covered as a diagnostic service.
Diabetes Education	40% Coinsurance after deductible	50% Coinsurance after deductible	$25 Copay
Nutritional Counseling	40% Coinsurance after deductible **Benefit Explanation** Covered for all diagnoses.	50% Coinsurance after deductible **Benefit Explanation** Covered for all diagnoses.	$60 Copay **Benefit Explanation** Subject to pre-approval, the policy covers charges for nutritional counseling for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Practitioner, and provided by a Practitioner.

Children's Vision

Eye Exam for Children	No Charge **Benefit Explanation** Covers vision screening for Dependent children, through age 17. **Limits & Exclusions** 1 Exam(s) per Year	No Charge **Benefit Explanation** Covers vision screening for Dependent children, through age 17. **Limits & Exclusions** 1 Exam(s) per Year	No Charge **Benefit Explanation** Covers 1 exam per calendar year for dependents age 19 and younger. **Limits & Exclusions** 1 Exam(s) per Year
Eye Glasses for Children	40% Coinsurance after deductible **Benefit Explanation** Vision benefits described in this provision for Covered Persons through age 18. We cover one pair of lenses, for glasses or contact lenses, and one pair of frames. **Limits & Exclusions** 1 Item(s) per Year	50% Coinsurance after deductible **Benefit Explanation** Vision benefits described in this provision for Covered Persons through age 18. We cover one pair of lenses, for glasses or contact lenses, and one pair of frames. **Limits & Exclusions** 1 Item(s) per Year	No Charge **Benefit Explanation** Coverage for 1 eyeglasses (lenses and frames) or contact lenses per calendar year for dependents through the end of the month in which he or she turns age 19. **Limits & Exclusions** 1 Item(s) per Year Standard frames refers to frames that are not designer frames such as Coach, Burberry, Prada and other designers.

Children's Dental

Basic Dental Care (Child)	40% Coinsurance after deductible	50% Coinsurance after deductible	Not Covered
Dental Check Up (Child)	No Charge **Limits & Exclusions** 1 Visit(s) per 6 Months	No Charge **Limits & Exclusions** 1 Visit(s) per 6 Months	Not Covered
Major Dental Care (Child)	40% Coinsurance after deductible	50% Coinsurance after deductible	Not Covered
Orthodontia (Adult)	Not Covered	Not Covered	Not Covered
Orthodontia (Child)	50% Coinsurance after deductible	50% Coinsurance after deductible	Not Covered

These are only estimates. Please complete an application through GetCoveredNJ to see your actual costs.

Explanation of terms used

Expense Estimate	The estimate is based on your answers about how much you will use healthcare -- in other words, how many times you will go to the doctor and how many prescriptions you have. (If you did not answer the questions we will assume that an average member of your household visits the doctor approximately 1-2 times per year and has approximately 0-2 prescriptions per year.)
$14467.84	
$12641.40	
$11825.80	
Plan Type	The type of health plan you choose determines your in- and out-of-network benefits. Common types include HMO, EPO, PPO, and POS.
EPO	An Exclusive Provider Organization (EPO) plan is a managed care plan where services are covered only if you use doctors, specialists or hospitals in the plan's network (except in an emergency).
HSA-compatible	Health Savings Accounts (HSAs) are savings accounts available through some high-deductible health plans as a way to save money for certain medical expenses. The funds contributed to the account aren't subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses, such as prescription drugs. Unlike a Flexible Spending Account (FSA), the funds in HSAs roll over year to year if you don't spend them.
Out-of-Pocket max	The maximum amount you'll pay out-of-pocket for your bills before the insurance company starts paying 100% of the costs.
Primary Care Visit	Estimated co-pay or co-insurance to visit a health care office or facility where services are provided by a physician, nurse practitioner or physician assistant to treat an injury or illness.
Specialist Visit	A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.
Other Practitioner Office Visit (Nurse, Physician Assistant)	Office visits for services from other health care providers such as registered dieticians or physical therapists.
Preventive Care/Screening/Immunization	Routine health care that includes screenings, check-ups and patient counseling to prevent illnesses, disease or other health problems.

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