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
	aetna CVS Health	oscar	United Healthcare
	Silver 2 Advanced: Aetna...	**Silver Classic**	**UHC Silver Advantage ($0...**
	SILVER EPO	SILVER EPO	SILVER EPO
	$751.58 /month	**$836.30 /month**	**$961.85 /month**
	after $866.00 savings	after $866.00 savings	after $866.00 savings
	ADD	ADD	ADD

Summary

Expense Estimate*	$12662.64	$13517.52	$14467.84
Plan Type *	EPO	EPO	EPO
HSA-compatible *	No	No	No

Deductible & Out-of-Pocket (In Network)

Deductible	$2500 (Individual) $5000 (Family)	$2500 (Individual) $5000 (Family)	$2500 (Individual) $5000 (Family)
Out-of-Pocket max *	$8850 (Individual) $17700 (Family)	$8900 (Individual) $17800 (Family)	$9200 (Individual) $18400 (Family)

Doctor Visit

Primary Care Visit *	$30 Copay **Benefit Explanation** Cost share applies to both in-person and virtual services from in-network providers. Cost share does not apply to virtual services from designated telemedicine providers. If this is an HSA plan, deductible applies.	$20 Copay **Benefit Explanation** Cost share applies to both in-person and telemedicine services.	$20 Copay **Benefit Explanation** Cost sharing for Virtual Primary Care matches in-person office visit.
Specialist Visit *	$75 Copay	$60 Copay **Benefit Explanation** Cost share applies to both in-person and telemedicine services.	$75 Copay
Other Practitioner Office Visit (Nurse, Physician Assistant) *	$30 Copay **Benefit Explanation** Cost share applies to both in-person and virtual services from in-network providers. Cost share does not apply to virtual services from designated telemedicine providers. If this is an HSA plan, deductible applies.	$20 Copay	40% Coinsurance after deductible
Preventive Care/Screening/Immunization *	No Charge	0% Coinsurance	No Charge

	Benefit Explanation Age and frequency schedules may apply.		

Tests

Laboratory Outpatient and Professional Services	$45 Copay	$75 Copay	$25 Copay after deductible
X-rays and Diagnostic Imaging	$75 Copay **Benefit Explanation** Member cost share based on place and type of service.	$70 Copay	$35 Copay after deductible
Imaging (CT/PET scans, MRIs)	40% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible

Drugs

Generic Drugs	$25 Copay **Benefit Explanation** Cost share could vary based on drug and pharmacy selected. Please see the Summary of Benefits & Coverage (SBC) or policy document for plan details.	$25 Copay	$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
Preferred Brand Drugs	$50 Copay **Benefit Explanation** Cost share could vary based on drug and pharmacy selected. Please see the Summary of Benefits & Coverage (SBC) or policy document for plan details.	50% Coinsurance after deductible	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
Non-Preferred Brand Drugs	40% Coinsurance **Benefit Explanation** Covered up to $150 maximum.	50% Coinsurance after deductible	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
Specialty drugs	40% Coinsurance **Benefit Explanation** Cost share could vary based on drug and pharmacy selected. Please see the Summary of Benefits & Coverage (SBC) or policy document for plan details.Covered up to $150 maximum.	50% Coinsurance after deductible	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

Outpatient

Outpatient Facility Fee	40% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible
Outpatient Surgery Physician/Surgical Services	40% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible

ER & Urgent Care

Emergency Room Services	$100 Copay after deductible 40% Coinsurance after deductible **Limits & Exclusions** No coverage for non-emergency use of the emergency room.	50% Coinsurance after deductible	$100 Copay with deductible 40% Coinsurance after deductible
Emergency Transportation/Ambulance	40% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible
Urgent Care	$75 Copay **Limits & Exclusions** No coverage for non-urgent care.	$75 Copay **Benefit Explanation** Virtual urgent care services provided by Oscar-designated virtual care providers are covered in full.	$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.

Hospital

Inpatient Hospital Services	40% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible
Inpatient Physician and Surgical Services	40% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible

Mental / Behavioral Health

Mental/Behavioral Health Outpatient Services	$30 Copay **Benefit Explanation** The cost sharing that displays applies to outpatient office visits only. All other outpatient services may be subject to additional cost sharing. Please refer to the plan policy documents for detailed information.	$20 Copay	$75 Copay
Mental/Behavioral Health Inpatient Services	40% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible
Substance Abuse Disorder Outpatient Services	$30 Copay **Benefit Explanation** Prior authorization is not required for the first 180 days of services	$20 Copay	$75 Copay
Substance Abuse Disorder Inpatient Services	40% Coinsurance after deductible **Benefit Explanation** Prior authorization is not required for the first 180 days of services	50% Coinsurance after deductible	40% Coinsurance after deductible

Pregnancy

Prenatal and postnatal care	40% Coinsurance after deductible **Benefit Explanation** Member cost sharing applies to postnatal care.	0% Coinsurance	No Charge
Delivery and All Inpatient Services for Maternity Care	40% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible **Benefit Explanation** Childbirth/delivery professional services follow inpatient physician/surgeon fees.

Other Special Needs

Home Healthcare Services	40% Coinsurance after deductible	$60 Copay **Limits & Exclusions** 60 Visit(s) per Year	40% Coinsurance after deductible
Outpatient Rehabilitation Services	40% Coinsurance after deductible	$75 Copay **Benefit Explanation** Coverage for Physical Therapy and Occupational Therapy, combined, is limited to 30 visits per	40% Coinsurance after deductible

	Benefit Explanation Coverage for Physical Therapy, Occupational Therapy, and Speech Therapy is limited to 30 visits each per calendar year. **Limits & Exclusions** 30 Visit(s) per Year	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	**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
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	$75 Copay **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	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
Skilled Nursing Facility	40% Coinsurance after deductible	50% Coinsurance after deductible **Benefit Explanation** Referred to as Extended Care Center.	40% Coinsurance after deductible **Benefit Explanation** Referred to as Extended Care Center
Durable Medical Equipment	50% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible
Hospice Services	40% Coinsurance after deductible **Benefit Explanation** Member cost share based on place and type of service.	50% Coinsurance after deductible	40% 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 **Benefit Explanation** Care or treatment by means of acupuncture is excluded except when used as a substitute for other forms of anesthesia.
Rehabilitative Speech Therapy	40% Coinsurance after deductible **Limits & Exclusions** 30 Visit(s) per Year	$75 Copay **Limits & Exclusions** 30 Visit(s) per Year	40% Coinsurance after deductible **Limits & Exclusions** 30 Visit(s) per Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	40% Coinsurance after deductible **Benefit Explanation** Coverage for Physical Therapy and Occupational Therapy is limited to 30 visits each per year. **Limits & Exclusions** 30 Visit(s) per Year	$75 Copay **Benefit Explanation** Coverage for occupational therapy and physical therapy combined is limited to 30 visits per Calendar Year. **Limits & Exclusions** 30 Visit(s) per Year	40% Coinsurance after deductible **Benefit Explanation** Coverage for occupational therapy and physical therapy combined is limited to 30 visits per Calendar Year. **Limits & Exclusions** 30 Visit(s) per Year
Well Baby Visits and Care	No Charge **Benefit Explanation** Age and frequency schedules may apply.	0% Coinsurance **Benefit Explanation** Under preventive care.	No Charge **Benefit Explanation** Under preventive care
Allergy Testing	$75 Copay **Benefit Explanation** Member cost share based on place and type of 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.	$75 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	$75 Copay **Benefit Explanation** Member cost share based on place and type of service.	$0 Copay	40% Coinsurance after deductible
Nutritional Counseling	No Charge **Benefit Explanation** Subject to Pre-Approval, 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.	$20 Copay	40% Coinsurance after deductible **Benefit Explanation** Covered for all diagnoses.

› Children's Vision

Eye Exam for Children	$10 Copay **Benefit Explanation** Coverage through the end of the month in which the member turns 19. **Limits & Exclusions** 1 Visit(s) per Year	$0 Copay **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
Eye Glasses for Children	$10 Copay **Benefit Explanation** Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses every 12 months through the end of the month in which the member turns 19. **Limits & Exclusions** 1 Item(s) per Year	50% Coinsurance **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 Standard frames refers to frames that are not designer frames such as Coach, Burberry, Prada and other designers.	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

Children's Dental

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

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.)
$12662.64	
$13517.52	
$14467.84	
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.