Get Covered NJ
New Jersey's Official Health Insurance Marketplace

Back to all plans

Compare Plans

	EXPENSE ESTIMATE LOW ($)	EXPENSE ESTIMATE LOW ($)	EXPENSE ESTIMATE LOW ($)
	MARKETPLACE PLAN	MARKETPLACE PLAN	MARKETPLACE PLAN
	oscar	Horizon	United Healthcare
	Bronze Classic	**OMNIA Bronze ($0 Horizon...**	**UHC Bronze Value ($0 Vir...**
	BRONZE EPO	BRONZE EPO	BRONZE EPO
	$564.65 /month	**$637.98 /month**	**$695.44 /month**
	after $866.00 savings	after $866.00 savings	after $866.00 savings
	ADD	ADD	ADD

Summary

Expense Estimate*	$11606.00	$12485.96	$12641.40
Plan Type *	EPO	EPO	EPO
HSA-compatible *	No	No	No

Deductible & Out-of-Pocket (In Network)

Deductible	$3000 (Individual) $6000 (Family)	$3000 (Individual) $6000 (Family)	$3000 (Individual) $6000 (Family)
Out-of-Pocket max *	$9100 (Individual) $18200 (Family)	$9200 (Individual) $18400 (Family)	$9200 (Individual) $18400 (Family)

Doctor Visit

Primary Care Visit *	$50 Copay after deductible **Benefit Explanation** Cost share applies to both in-person and telemedicine services.	$50 Copay after deductible	$50 Copay **Benefit Explanation** Cost sharing for Virtual Primary Care matches in-person office visit.
Specialist Visit *	$75 Copay after deductible **Benefit Explanation** Cost share applies to both in-person and telemedicine services.	$75 Copay after deductible	$75 Copay after deductible
Other Practitioner Office Visit (Nurse, Physician Assistant) *	$50 Copay after deductible	$75 Copay after deductible **Benefit Explanation** All member cost sharing varies based upon Place of Service. Please refer to plan documents for additional information.	50% Coinsurance after deductible
Preventive Care/Screening/Immunization *	0% Coinsurance	No Charge	No Charge

Tests

Laboratory Outpatient and Professional Services	$75 Copay	50% Coinsurance after deductible **Benefit Explanation** All member cost sharing varies based upon Place of Service. Please refer to plan documents for additional information.	50% Coinsurance after deductible
X-rays and Diagnostic Imaging	$75 Copay after deductible	50% Coinsurance after deductible **Benefit Explanation** All member cost sharing varies based upon Place of Service. Please refer to plan documents for additional information.	50% Coinsurance after deductible
Imaging (CT/PET scans, MRIs)	50% Coinsurance after deductible	50% Coinsurance after deductible **Benefit Explanation** All member cost sharing varies based upon Place of Service. Please refer to plan documents for additional information.	50% Coinsurance after deductible

Drugs

Generic Drugs	$25 Copay	$25 Copay **Benefit Explanation** Please refer to your drug guide for information regarding different tiers of drug coverage and applicable prior authorization, medical necessity review, and dispensing limits.	$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
Preferred Brand Drugs	50% Coinsurance after deductible	50% Coinsurance after deductible **Benefit Explanation** Please refer to your drug guide for information regarding different tiers of drug coverage and applicable prior authorization, medical necessity review, and dispensing limits.	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	50% Coinsurance after deductible	50% Coinsurance after deductible **Benefit Explanation** Please refer to your drug guide for information regarding different tiers of drug coverage and applicable prior authorization, medical necessity review, and dispensing limits.	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	50% Coinsurance after deductible	50% Coinsurance after deductible **Benefit Explanation** Please refer to your drug guide for information regarding different tiers of drug coverage and applicable prior authorization, medical necessity review, and dispensing limits.	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	50% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible
Outpatient Surgery Physician/Surgical Services	50% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible

ER & Urgent Care

Emergency Room Services	50% Coinsurance after deductible	$100 Copay with deductible 50% Coinsurance after deductible **Benefit Explanation** $100 copay is waived if admitted within 24hrs. Out-of-network payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries.	$100 Copay with deductible 50% Coinsurance after deductible
Emergency Transportation/Ambulance	50% Coinsurance after deductible	No Charge after deductible **Benefit Explanation** Out-of-network payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries.	50% Coinsurance after deductible
Urgent Care	$75 Copay after deductible **Benefit Explanation** Virtual urgent care services provided by Oscar-designated virtual care providers are covered in full.	$75 Copay after deductible	$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.

Hospital

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

Mental / Behavioral Health

Mental/Behavioral Health Outpatient Services	$50 Copay after deductible	50% Coinsurance after deductible	$75 Copay after deductible
Mental/Behavioral Health Inpatient Services	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible
Substance Abuse Disorder Outpatient Services	$50 Copay after deductible	50% Coinsurance after deductible **Benefit Explanation** For the first 180 days per plan year of inpatient and outpatient stay, treatment of substance use disorders must be provided when determined to be medically necessary by the member's licensed physician, psychologist or psychiatrist without any prior authorization or other prospective utilization management requirements.	$75 Copay after deductible
Substance Abuse Disorder Inpatient Services	50% Coinsurance after deductible	50% Coinsurance after deductible **Benefit Explanation** For the first 180 days per plan year of inpatient and outpatient stay, treatment of substance use disorders must be provided when determined to be medically necessary by the member's licensed physician, psychologist or psychiatrist without any prior authorization or other prospective utilization management requirements.	50% Coinsurance after deductible

Pregnancy

Prenatal and postnatal care	0% Coinsurance	$75 Copay after deductible	No Charge
Delivery and All Inpatient Services for Maternity Care	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible **Benefit Explanation** Childbirth/delivery professional services follow inpatient physician/surgeon fees.

Other Special Needs

Home Healthcare Services	$75 Copay after deductible **Limits & Exclusions** 60 Visit(s) per Year	$25 Copay after deductible **Benefit Explanation** The Private Duty Nursing benefit is only covered as part of a Home Health Care plan. Please refer to plan documents for additional information.	50% Coinsurance after deductible
Outpatient Rehabilitation Services	$50 Copay 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 **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
Habilitation Services	$50 Copay 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** Habilitation services are subject to the limits applicable to rehabilitation services, other therapies, services and supplies. 30-visit limit does not apply to the treatment of autism or other developmental disabilities. See Explanation. All member cost sharing varies based upon Place of Service. Please refer to plan documents for additional information. **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
Skilled Nursing Facility	50% Coinsurance after deductible **Benefit Explanation** Referred to as Extended Care Center.	50% Coinsurance after deductible **Benefit Explanation** Please refer to plan documents for additional information.	50% Coinsurance after deductible **Benefit Explanation** Referred to as Extended Care Center
Durable Medical Equipment	50% Coinsurance after deductible	50% Coinsurance after deductible **Benefit Explanation** All member cost sharing varies based upon Place of Service. Please refer to plan documents for additional information.	50% Coinsurance after deductible
Hospice Services	50% Coinsurance after deductible	50% Coinsurance after deductible **Benefit Explanation** All member cost sharing varies based upon Place of Service. Please refer to plan documents for additional information.	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** Acupuncture is covered when used as an alternative to 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	$50 Copay after deductible **Limits & Exclusions** 30 Visit(s) per Year	50% Coinsurance after deductible **Benefit Explanation** All member cost sharing varies based upon Place of Service. Please refer to plan documents for additional information. **Limits & Exclusions** 30 Visit(s) per Year	50% Coinsurance after deductible **Limits & Exclusions** 30 Visit(s) per Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	$50 Copay 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	50% Coinsurance after deductible **Benefit Explanation** All member cost sharing varies based upon Place of Service. Please refer to plan documents for additional information. **Limits & Exclusions** 30 Visit(s) per Year	50% 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	0% Coinsurance **Benefit Explanation** Under preventive care.	No Charge	No Charge **Benefit Explanation** Under preventive care
Allergy Testing	$75 Copay after deductible	$75 Copay after deductible	$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.	**Benefit Explanation** All member cost sharing varies based upon Place of Service. Please refer to plan documents for additional information.	**Benefit Explanation** The policy covers non-surgical care and treatment which includes diagnostic services. Allergy testing is covered as a diagnostic service.
Diabetes Education	$0 Copay	$75 Copay after deductible **Benefit Explanation** All member cost sharing varies based upon Place of Service. Please refer to plan documents for additional information.	50% Coinsurance after deductible
Nutritional Counseling	$50 Copay after deductible	$50 Copay after deductible **Benefit Explanation** All member cost sharing varies based upon Place of Service. Please refer to plan documents for additional information.	50% Coinsurance after deductible **Benefit Explanation** Covered for all diagnoses.

Children's Vision

Eye Exam for Children	$0 Copay **Benefit Explanation** Covers vision screening for Dependent children, through age 17. **Limits & Exclusions** 1 Exam(s) per Year	No Charge **Limits & Exclusions** 1 Visit(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	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.	No Charge **Benefit Explanation** Eyeglasses for Children are covered without cost sharing once every 12 months up to $150 allowance. Expenses for eyeglasses for children that are over $150 are subject to cost sharing and are covered once every 12 months. Please refer to Plan Brochure for limits and exclusions. **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

Children's Dental

Basic Dental Care (Child)	Not Covered	Not Covered	50% 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	50% 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.)
$11606.00	
$12485.96	
$12641.40	
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.