

### Individual Plans Summary

Cost-sharing and Services Description	Standard Individual Plans				HMO Plan	Basic & Essential Plan (w/out riders)
	Plans A/50 through D (may be offered with or without a PPO-feature)					
Cost-sharing	A/50	B	C	D		
Deductible carriers <i>must</i> offer	Per person: \$2500 Per family: \$5000				None	N/A
Deductible options carrier <i>may</i> offer	Per person: \$1000, \$5000 and/or \$10,000 Per family: \$2000, \$10,000 and/or \$20,000				Person: \$1000 or \$2500 Family: \$2000 or \$5000	N/A
Coinsurance paid by the covered person (you)	50%	40%	30%	20%	Options: 50%, 40%, 30%, 20%	30% for treatment of substance abuse and biologically-based mental illness 20% for wellness visits
Max Out-of-Pocket (paid by you) <b>MOOP = the Deductible + →</b>	\$5000	\$3000	\$2500	\$2000	No greater than \$5000	None
so, the range of the MOOP per person can be →	\$6000-\$15,000	\$4500-\$13,000	\$3500-\$12,500	\$3000-\$12,000		
so, the range of the MOOP per family can be →	\$7,000-\$25,000	\$5000-\$23,000	\$4500-\$22,500	\$4000-\$22,000		
ER Copayment (waived if admitted w/in 24 hrs) → in addition to the deductible and coinsurance (if any)	\$100	\$100	\$100	\$100	\$100	\$100
Copayments (per visit/day/confinement):						
>Hospital Confinement – max 5 copays/confinement; max 10 copays/year	When offering these plans with a PPO feature, carriers <i>may</i> use HMO copayment for in-network services, following the rules for the HMO plan (instead of deductible and coinsurance). Out-of-network services will be subject to deductible and coinsurance requirements.  <i>If the PPO plan uses deductible and coinsurance for both in-network and out-of-network services, the deductible and/or coinsurance out-of-network will more than the deductible and coinsurance for in-network services.</i>				Carrier <i>must</i> offer: \$300/day Carrier <i>may</i> offer: \$150, \$400 and \$500/day	\$500/confinement (no maximums)
>Pre-natal Care – copayment charged <i>only</i> for initial visit					\$25 OR same copayment as physician visit	Not covered
>Other services & supplies					Carriers <i>must</i> offer: \$30/visit Carriers <i>may</i> offer: \$15, \$40, and \$50/visit Carriers <i>may</i> offer a split copay → higher copays for specialist visits	Not applicable except for physical therapy → \$20/visit
Lifetime Maximum Benefit	Unlimited				Unlimited	Unlimited

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Covered Charges/Covered Services and Supplies	Plans A/50 – D	HMO Plan	
Hospital	Covered	Covered	covered up to 90 days/year
Emergency and urgent care	Covered	Covered	Emergency covered
Preadmission testing	Covered	Covered	Covered
Ambulatory surgical center	Covered	Covered	Not covered
Extended Care or Rehabilitation	Up to 120 days/year; requires preapproval	Covered; requires preapproval	Not covered
Home health care	Covered; requires preapproval	Covered; requires preapproval	Not covered
Hospice care	Covered; requires preapproval	Covered; requires preapproval	Not covered
Practitioner charges – surgical and nonsurgical, including second opinions	Covered	Covered	Up to \$700/year; second opinion not covered
Preventive care (as required by federal law); Wellness care in the Basic & Essential plans	Covered – no deductible or copayments apply; for PPO plans: unlimited in-network; \$500/person/year or \$750 through 1 year old out-of-network	Covered	Up to \$600/person/year
Mammogram	Covered; age and frequency limits may apply	Covered	Diagnostic tests limited to \$500/year
Colorectal cancer screenings	Covered; age limits apply	Covered	Diagnostic tests limited to \$500/year
Dialysis center/treatments	Covered	Covered	Covered
Prescription drugs (outpatient)	Covered; may require preapproval; coinsurance for Rx does not apply to the MOOP	Covered at 50% coinsurance; may require preapproval	Not covered
Supplies to administer Rx drugs	Covered	Covered	Not covered
Alcohol abuse treatment	Covered	Covered	30 days inpatient; 30 visits outpatient
Biologically-based mental illness treatment (including autism)	Covered	Covered	90 days inpatient; 30 visits outpatient
Non-biologically-based mental illness treatment and substance abuse treatment	30 days inpatient; 20 visits outpatient; may exchange inpatient days for outpatient visits; requires preapproval	30 days inpatient; 20 visits outpatient; may exchange inpatient days for outpatient visits; requires preapproval	Non-biologically based mental illness treatment is not covered; for substance abuse, see alcohol abuse treatment
Pregnancy	Covered	Covered	Covered: delivery and use of the delivery room only
Birth center	Covered	Covered	Not covered

Covered Charges/Covered Services and Supplies	Plans A/50 – D	HMO Plan	Basic & Essential Plan (w/out riders)
Newborn child coverage	Unless the child is added to the policy, covered for first 31 days only	Unless the child is added to the policy, covered for first 31 days only	Unless the child is added to the policy, covered for first 31 days only
Specialized infant formula	Covered	Covered	Not covered
Immunizations and lead screening	Covered; deductible does not apply	Covered	Covered
Newborn hearing screening	Covered; limited benefit	Covered; limited benefit	Not covered
Anesthesia	Covered	Covered	Covered
Blood	Covered	Covered	Covered
Ambulance	Covered	Covered	Not covered
Durable medical equipment	Covered; requires preapproval	Covered	Not covered
Nutritional counseling	Covered; requires preapproval	Covered	Not covered
Food and food products for inherited metabolic diseases	Covered	Covered	Not covered
X-rays and laboratory tests	Covered	Covered	Covered
Dental care and treatment	Covered for tumors, cysts, bony impacted teeth, injury to teeth or jaw	Covered for tumors, cysts, bony impacted teeth, injury to teeth or jaw	Not covered
TMJ	Covered, but excludes orthodontia, crowns, bridgework	Covered, but excludes orthodontia, crowns, bridgework	Not covered
Orthotic appliances and prosthetic devices	Covered; requires preapproval	Covered	Not covered
Hearing aids	Up to \$1000/ear every 24 months for children under 16 years old	Up to \$1000/ear every 24 months for children under 16 years old	Not covered
Treatment of autism and other developmental disabilities:			
Physical therapy	Up to 30 visits/year	Up to 30 visits/year	Not covered
Occupational therapy	Up to 30 visits/year	Up to 30 visits/year	Not covered
Speech therapy	Up to 30 visits/year	Up to 30 visits/year	Not covered
Cognitive therapy	Up to 30 visits/year	Up to 30 visits/year	Not covered
Applied behavior analysis	Up to \$36,000/year (w/ annual adjustment) for treatment of autism in individuals under 21 years old	Up to \$36,000/year (w/ annual adjustment) for treatment of autism in individuals under 21 years old	Not covered
Family cost share for NJ Early Intervention Services	Covered for PT, OT, and ST to treat a diagnosed developmental disability or autism only	Covered for PT, OT, and ST to treat a diagnosed developmental disability or autism only	Not covered

Covered Charges/Covered Services and Supplies	Plans A/50 – D	HMO Plan	Basic & Essential Plan (w/out riders)
Transplant benefits	Covered, but specified procedures only	Covered, but specified procedures only	Not covered
Surgical treatment of morbid obesity	Covered but specific criteria must be met	Covered but specific criteria must be met	Not covered
Physical therapy	Up to 30 visits/year; may require preapproval	Up to 30 visits/year; may require preapproval	Up to 30 visits/year
Occupational therapy	Up to 30 visits/year; may require preapproval	Up to 30 visits/year; may require preapproval	Not covered
Speech therapy	Up to 30 visits/year; may require preapproval	Up to 30 visits/year; may require preapproval	Not covered
Cognitive rehabilitation therapy	Up to 30 visits/year; may require preapproval	Up to 30 visits/year; may require preapproval	Not covered
Chelation therapy	Covered	Covered	Not covered
Chemotherapy	Covered	Covered	Not covered
Radiation therapy	Covered	Covered	Covered
Respiration therapy	Covered	Covered	Not covered
Visions screening	Covered; limited benefit; eye exams not covered	Covered; limited benefit; eye exams not covered	Not covered
Therapeutic Manipulation (chiropractic)	Up to 30 visits/year	Up to 30 visits/year	Not covered