

SUMMARIES OF COVERAGE & MONTHLY PREMIUM RATES NEW JERSEY INDIVIDUAL PLANS

NEW JERSEY INDIVIDUAL PLANS

NJ INDIVIDUAL LIBERTY HMO

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NJ INDIVIDUAL BASIC AND ESSENTIAL EPO

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NJ INDIVIDUAL BASIC AND ESSENTIAL ENHANCED

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NJ INDIVIDUAL INDEMNITY (PLANS: A/50, B, C, D)

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IMPORTANT NOTE:

For ease of processing, we would like to encourage applications to be submitted by the 25th of the month; however, all applications received by the 31st of the month will be accepted for an effective date of the first of the following month. Oxford reserves the right to correct any typographical errors or to make changes permitted by regulation.

Please send your application along with the appropriate premium to:

**Oxford Health Plans
Attn: Individual Plan
14 Central Park Drive
Hooksett NH 03106**



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NJ INDIVIDUAL LIBERTY HMO SUMMARY OF COVERAGE

\$15 office visit copayment

\$30 office visit copayment

BENEFIT	IN-NETWORK ONLY
Financial	
Deductible	
Single	None
Family	None
Coinsurance	None
Maximum Lifetime Benefit per Member	Unlimited
Outpatient & Preventive Care	
Primary Care Physician Services	Copayment per visit
Specialist Services	Copayment per visit (with referral from PCP)
Physician Outpatient Services	Copayment per visit; waived if any other copayment applies
Second Surgical Option	Copayment per visit
Preadmission Testing	Copayment per visit
Pediatric Services	Copayment per visit; excludes routine foot care
Laboratory Procedures, X-Ray Examinations	Copayment per visit
Hospital Care	
Physician Inpatient Services	No copayment
Inpatient Hospital Services* (Unlimited Days)	\$150/\$300 copayment per day for a maximum of 5 days per admission; maximum copayment \$1500/\$3000 per calendar year
Outpatient Hospital Services*	Copayment per visit
Ambulatory Surgery*	Copayment per visit
Emergency Care	
(Oxford must be contacted within 48 hours)	
Emergency Room Services	\$100 copayment per visit; credited toward inpatient admission if admission occurs within 24 hours as a result of the emergency
Maternity Care	
Prenatal Care	\$25 copayment/initial visit
Birthing Centers	Copayment per visit
Delivery	Subject to inpatient hospital stay copayment for mother and baby
Non-biologically based Mental Illness and Substance Abuse	
Inpatient Care*	\$150/\$300 copayment per day for a maximum of five (5) days per admission; maximum copayment \$1500/\$3000 per calendar year. Maximum 30 inpatient days per calendar year (one inpatient day may be exchanged for two (2) outpatient visits or partial hospital days. Pre-approval is required for exchange).
Outpatient Care	Copayment per visit Maximum of 20 visits per calendar year

NOTE: Biologically based mental illnesses will be treated the same as any other illness. Limitation on visits does not apply.



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BENEFIT	IN-NETWORK ONLY
Alcoholism	
Inpatient Care*	\$150/\$300 copayment per day for a maximum of 5 days per admission; maximum copayment \$1500/\$3000 per calendar year
Outpatient Care	Copayment per visit
Specialty Care	
Home Health Care*	Unlimited days, if pre-approved
Skilled Nursing Care*	Unlimited days, if pre-approved
Hospice Services*	Unlimited days, if pre-approved
Therapy Services	
Speech, Physical, Occupational and Cognitive Therapies	Copayment 30 days per therapy, per calendar year
Chemotherapy, Dialysis and Infusion and Radiation	Copayment Unlimited (subject to pre-approval and copayment)
Therapeutic Manipulation (Chiropractic Care)	
Practitioner Services (Maximum benefit: 30 visits per calendar year)	Copayment
Prescription Drugs	
Per Generic/Brand Name Prescription	50% coinsurance
Diabetic Supplies	50% coinsurance
Other Items	
Durable Medical Equipment*, when Medically Necessary	No charge if precertified by Oxford in advance and ordered by an Oxford participating physician

DEPENDENT ELIGIBILITY:

Eligible dependents include the subscriber's legal spouse and dependent child(ren) until the child(ren) reach age 19, or age 23 if a full time student. Benefits discontinue on the day the birthday occurs.

* These services require **precertification** through Oxford. You must call Oxford at 800-444-6222 at least 14 days in advance of request. Mental health and substance abuse services can be precertified through Oxford's Behavioral Health Department by calling 800-201-6991. A complete list of radiological services requiring precertification can be found in your Summary of Benefits. Radiological services can be precertified by calling 877-PRE-AUTH.

No benefits will be provided if you fail to obtain a referral from your primary care physician. Benefits for a pre-existing condition may not be covered for the first 12 months of your enrollment. **Please note:** This is intended only as a general summary of benefits. All benefits are subject to terms of your HMO individual contract. More complete descriptions of benefits and the terms under which they are provided, including limitations and exclusions, are contained in your contract



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NJ INDIVIDUAL LIBERTY HMO RATES

January 2007 - June 2007

\$15 Copayment HMO Option

	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07
Single	\$564.18	\$566.93	\$569.69	\$572.46	\$575.25	\$578.05
Parent/Child(ren)	\$1,071.94	\$1,077.17	\$1,082.41	\$1,087.67	\$1,092.98	\$1,098.30
Husband/Wife	\$1,128.36	\$1,133.86	\$1,139.38	\$1,144.92	\$1,150.50	\$1,156.10
Family	\$1,692.54	\$1,700.79	\$1,709.07	\$1,717.38	\$1,725.75	\$1,734.15

\$30 Copayment HMO Option

	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07
Single	\$425.54	\$427.61	\$429.69	\$431.78	\$433.89	\$436.00
Parent/Child(ren)	\$808.53	\$812.46	\$816.41	\$820.38	\$824.39	\$828.40
Husband/Wife	\$851.08	\$855.22	\$859.38	\$863.56	\$867.78	\$872.00
Family	\$1,276.62	\$1,282.83	\$1,289.07	\$1,295.34	\$1,301.67	\$1,308.00



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NJ INDIVIDUAL LIBERTY PPO SUMMARY OF COVERAGE

Plan C	Plan C	Plan D
\$15 copayment	\$30 copayment	\$30 copayment
70%/30% coinsurance	70%/30% coinsurance	80%/20% coinsurance
\$1,000 single deductible	\$2,500 single deductible	\$1,000 single deductible
\$2,000 family deductible	\$5,000 family deductible	\$2,000 family deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Financials		
Deductible		
Single	\$1,000 or \$2500 deductible	\$2,000 or \$5,000 deductible
Family ¹	\$2,000 or \$5000 deductible	\$4,000 or \$10,000 deductible
Coinsurance (per person, per year)	Plan C 30% or Plan D 20%	Plan C 30% or Plan D 20%
Single Maximum Out of Pocket	\$5,000	\$10,000
Office Visit Copayment	\$15 or \$30 copayment	Subject to deductible & coinsurance
Preventive Care Maximum		
Under 1 year	100% up to \$750 per person per calendar year; no coverage thereafter; combined in & out of network	100% up to \$750 per person per calendar year; no coverage thereafter; combined in & out of network
1 year and over	100% up to \$500 per person per calendar year; not subject to deductible and coinsurance; combined in & out of network	100% up to \$500 per person per calendar year; not subject to deductible and coinsurance
Maximum Lifetime Benefit per Member	Unlimited	Unlimited
Outpatient Care		
Office visits	\$15 or \$30 copayment	Subject to deductible & coinsurance
Ambulatory surgical facility	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Second surgical opinions	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Pre-admission testing	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Laboratory services	No charge at Quest Diagnostic Laboratories; Subject to deductible & coinsurance at other participating laboratories	Subject to deductible & coinsurance
Magnetic Resonance Imaging (MRI)	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Hospital Care		
Inpatient Care* (up to 365 days) if preapproved	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Other Covered Charges	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Emergency Care (Copayment is credited toward Inpatient admission if admission occurs within 24 hours.)		
(Oxford must be contacted within 48 hours)		
Ambulance Service for a Medical Emergency	No charge	Subject to deductible & coinsurance
Emergency Room	\$100 copayment per visit per covered person ¹	\$100 copayment per visit per covered person ¹
Emergency care in Urgi-Center	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Maternity Care		
Prenatal care	\$15 or \$30 copayment (initial visit only)	Subject to deductible & coinsurance
Delivery Postnatal Care and Hospital Services for Mother and Child	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Therapy Services		
30 visits per covered person per calendar year for each of the following: Physical, Occupational, Speech and Cognitive Rehabilitation	\$15 or \$30 copayment	Subject to deductible & coinsurance
Radiation Therapy, Chemotherapy, Chelation, Dialysis, and Respiration Therapy is covered as any other illness, without visit limitation, Infusion Therapy is subject to pre-approval.		

¹Copayment is in addition to any applicable coinsurance and/or deductible.



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BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Home Health Care		
Unlimited Days, if Pre-approved	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Skilled Nursing Care		
120 Days of Confinement per Covered Person if Pre-approved	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Non-biologically based Mental Illness and Substance Abuse (at approved facilities only)		
Inpatient (30 day limit)	Subject to deductible & coinsurance	Subject to deductible & coinsurance;
Outpatient (20 visit limit)	\$15 or \$30 copayment	Subject to deductible & coinsurance;
NOTE: Biologically based mental illnesses will be treated the same as any other illness. Limitation on visits does not apply. You may be able to exchange 1 inpatient day for 2 outpatient visits. Pre-approval is required.		
Therapeutic Manipulation		
Practitioner's services Maximum benefit: 30 visits per calendar year	\$15 or \$30 copayment	Subject to deductible & coinsurance
Hospice Care		
Unlimited Days, if Pre approved	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Prescription Drugs		
Per Generic/Brand Name Prescription Diabetic Supplies	50% coinsurance Subject to deductible & coinsurance	None Subject to deductible & coinsurance
Other Items		
Durable Medical Equipment when Medically Necessary (requires precapproval)	Subject to deductible & coinsurance	Subject to deductible & coinsurance

DEPENDENT ELIGIBILITY:

Eligible dependents include subscriber's spouse and dependent child(ren) until the child(ren) reach age 19, or age 23 if a full time student. Benefits discontinue end-of month in which birthday occurs.

¹ The family deductible is the equivalent of two single deductibles. The maximum amount an individual family member can credit toward the family deductible may not exceed the single deductible.

PLEASE NOTE: This is intended as a general summary of benefits. More complete descriptions of benefits and the terms under which they are provided are contained in your OHI policy. Our payments, as noted above, will be reduced for noncompliance with the utilization review provisions contained in this policy. Read these provisions carefully before obtaining medical care, services or supplies. Refer to sections of this policy called "Covered Charges" and "Charges Covered with Special Limitations" to see what services and supplies are eligible for benefits. Refer to the section of this policy called "Exclusions" to see what services and supplies are not eligible for benefits.



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NJ INDIVIDUAL LIBERTY PPO RATES

January 2007 - June 2007

\$15 Office Visit Copayment with Plan C - \$1,000/\$2,000 Deductible*

	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07
Single	\$498.11	\$502.08	\$506.09	\$510.12	\$514.19	\$518.29
Parent/Child(ren)	\$921.50	\$928.85	\$936.27	\$943.72	\$951.25	\$958.84
Husband/Wife	\$996.22	\$1,004.16	\$1,012.18	\$1,020.24	\$1,028.38	\$1,036.58
Family	\$1,419.61	\$1,430.93	\$1,442.36	\$1,453.84	\$1,465.44	\$1,477.13

\$30 Office Visit Copayment with Plan C - \$2,500/\$5,000 Deductible*

	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07
Single	\$385.22	\$388.29	\$391.39	\$394.51	\$397.65	\$400.82
Parent/Child(ren)	\$712.66	\$718.34	\$724.07	\$729.84	\$735.65	\$741.52
Husband/Wife	\$770.44	\$776.58	\$782.78	\$789.02	\$795.30	\$801.64
Family	\$1,097.88	\$1,106.63	\$1,115.46	\$1,124.35	\$1,133.30	\$1,142.34

\$30 Office Visit Copayment with Plan D - \$1,000/\$2,000 Deductible*

	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07
Single	\$540.02	\$544.33	\$548.67	\$553.04	\$557.45	\$561.90
Parent/Child(ren)	\$999.04	\$1,007.01	\$1,015.04	\$1,023.12	\$1,031.28	\$1,039.52
Husband/Wife	\$1,080.04	\$1,088.66	\$1,097.34	\$1,106.08	\$1,114.90	\$1,123.80
Family	\$1,539.06	\$1,551.34	\$1,563.71	\$1,576.16	\$1,588.73	\$1,601.42

*All plans include a 50% copayment prescription drug benefit



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NJ INDIVIDUAL BASIC AND ESSENTIAL EPO

SUMMARY OF COVERAGE

IN-NETWORK COVERAGE ONLY

Outpatient Care

Alcohol & Substance Abuse	30% coinsurance per visit, up to 30 visits maximum per covered person, per calendar year
Ambulatory Surgical Facility	\$250 copayment per covered person, per surgery
Biologically Based Mental Illness Outpatient Care	30% coinsurance per visit, up to 30 visits maximum per covered person, per calendar year
Emergency Room Services	\$100 copayment per covered person, per visit
Outpatient Diagnostic Testing	100% coverage up to a \$500 maximum per covered person, per calendar year
Outpatient Physical Therapy	\$20 copayment per visit, up to 30 visits maximum per covered person, per calendar year
Practitioner Visits for Illness or Injury (includes urgent care facility visits, office visit and inpatient hospital visits)	100% coverage up to a \$700 maximum per covered person, per calendar year
Wellness Benefit	\$50 annual deductible, 20% coinsurance up to \$600 maximum per covered person, per calendar year

Exclusions from Coverage: Other Outpatient Care Items

Ambulance Services	Not covered
Chemotherapy	Not covered
Diabetic Supplies, Self Education and Management	Not covered
Durable Medical Equipment (DME)	Not covered
Fertility Enhancement Services and Procedures	Not covered
Home Health Care Services (including visits)	Not covered
Infusion Therapy	Not covered
Medical Supplies	Not covered
Nutritional Counseling	Not covered
Occupational and Speech Therapy	Not covered
Postnatal Care	Not covered
Prenatal Care (except practitioner charges for delivery and complications)	Not covered
Prescription Drugs	Not covered
Private Duty Nursing	Not covered
Second Surgical Opinion	Not covered
Temporomandibular Joint Disorder Treatment	Not covered
Therapeutic Manipulation	Not covered
Therapeutic Injections	Not covered
Transplants	Not covered
Treatment of Non-biologically Based Mental Illness	Not covered
Out-of-Network Services Other Than Emergency	Not covered



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IN-NETWORK COVERAGE ONLY

Inpatient Care

Alcohol & Substance Abuse Inpatient Facility Services	30% coinsurance after a \$500 copayment up to 30 days per period of confinement, up to 30 days maximum, per calendar year
Inpatient for Biologically Based Mental Illness	\$500 copayment per covered person per period of confinement up to 90 days maximum per covered person, per calendar year
Inpatient Facility Services	\$500 copayment per covered person per period of confinement up to 90 days maximum, per calendar year
Inpatient Practitioner Visits	See practitioner visits for illness or injury under Outpatient Care

Exclusions from Coverage: Other Inpatient Care Items

Hospice Care	Not covered
Skilled Nursing Care	Not covered
Out of Network services other than Emergency	Not covered

The Following Services Require Pre-approval:

Inpatient hospital admissions and procedures, as more specifically provided in the Oxford Individual Basic and Essential Health Care Services Plan Certificate.



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NJ INDIVIDUAL BASIC AND ESSENTIAL EPO RATES

September 2006 - February 2007



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Monthly Rates for Territories A, B and D

Territory A: Essex, Hudson and Union Counties

Territory B: Bergen and Passaic Counties

Territory D: Hunterdon, Middlesex and Somerset Counties

Please Note: Rates are based on the primary subscribers gender (male or female). Example: A 35 year old male subscriber living in Essex County applying for Parent/Child(ren) coverage in September 2006 would pay a monthly premium of \$495.57 where a 55 year old female subscriber living in Essex County applying for Family coverage would pay \$843.04.

SEPTEMBER 2006

	SINGLE		PARENT/CHILD(REN)		HUSBAND/WIFE		FAMILY	
	Male	Female	Male	Female	Male	Female	Male	Female
<25-29	\$150.95	\$165.19	\$629.89	\$649.37	\$239.24	\$239.24	\$780.38	\$780.38
30-39	\$176.58	\$207.91	\$495.57	\$487.03	\$301.90	\$301.90	\$754.75	\$754.75
40-49	\$233.54	\$227.85	\$461.39	\$447.15	\$358.86	\$358.86	\$757.59	\$757.59
50-59	\$310.44	\$259.18	\$541.14	\$526.90	\$458.54	\$458.54	\$843.04	\$843.04
60-65+	\$432.91	\$489.87	\$737.66	\$806.01	\$549.68	\$549.68	\$968.35	\$968.35

OCTOBER 2006

	SINGLE		PARENT/CHILD(REN)		HUSBAND/WIFE		FAMILY	
	Male	Female	Male	Female	Male	Female	Male	Female
<25-29	\$152.16	\$166.51	\$625.86	\$654.57	\$241.16	\$241.16	\$786.63	\$786.63
30-39	\$178.00	\$209.58	\$499.54	\$490.92	\$304.32	\$304.32	\$760.79	\$760.79
40-49	\$235.41	\$229.67	\$465.09	\$450.73	\$361.73	\$361.73	\$763.66	\$763.66
50-59	\$312.93	\$261.25	\$545.47	\$531.12	\$462.21	\$462.21	\$849.79	\$849.79
60-65+	\$436.38	\$493.79	\$743.56	\$812.46	\$554.08	\$554.08	\$976.11	\$976.11

NOVEMBER 2006

	SINGLE		PARENT/CHILD(REN)		HUSBAND/WIFE		FAMILY	
	Male	Female	Male	Female	Male	Female	Male	Female
<25-29	\$153.37	\$167.83	\$630.83	\$659.76	\$243.07	\$243.07	\$792.87	\$792.87
30-39	\$179.41	\$211.24	\$503.50	\$494.82	\$306.73	\$306.73	\$766.83	\$766.83
40-49	\$237.28	\$231.50	\$468.78	\$454.31	\$364.61	\$364.61	\$769.72	\$769.72
50-59	\$315.41	\$263.33	\$549.80	\$535.33	\$465.89	\$465.89	\$856.54	\$856.54
60-65+	\$439.84	\$497.72	\$749.47	\$818.92	\$558.48	\$558.48	\$983.86	\$983.86

NJ INDIVIDUAL BASIC AND ESSENTIAL EPO RATES

September 2006 - February 2007



A UnitedHealthcare Company

Monthly Rates for Territories A, B and D

Territory A: Essex, Hudson and Union Counties

Territory B: Bergen and Passaic Counties

Territory D: Hunterdon, Middlesex and Somerset Counties

Please Note: Rates are based on the primary subscribers gender (male or female). Example: A 35 year old male subscriber living in Essex County applying for Parent/Child(ren) coverage in March 2006 would pay a monthly premium of \$472.51 where a 55 year old female subscriber living in Essex County applying for Family coverage would pay \$803.82.

DECEMBER 2006

	SINGLE		PARENT/CHILD(REN)		HUSBAND/WIFE		FAMILY	
	Male	Female	Male	Female	Male	Female	Male	Female
<25-29	\$154.59	\$169.17	\$635.86	\$665.03	\$245.01	\$245.01	\$799.20	\$799.20
30-39	\$180.84	\$212.93	\$507.52	\$498.77	\$309.18	\$309.18	\$772.95	\$772.95
40-49	\$239.18	\$233.34	\$472.52	\$457.94	\$367.52	\$367.52	\$775.87	\$775.87
50-59	\$317.93	\$265.43	\$554.19	\$539.61	\$469.60	\$469.60	\$863.37	\$863.37
60-65+	\$443.35	\$501.69	\$755.45	\$825.45	\$562.94	\$562.94	\$991.71	\$991.71

JANUARY 2007

	SINGLE		PARENT/CHILD(REN)		HUSBAND/WIFE		FAMILY	
	Male	Female	Male	Female	Male	Female	Male	Female
<25-29	\$155.83	\$170.53	\$640.94	\$670.34	\$246.97	\$246.97	\$805.59	\$805.59
30-39	\$182.29	\$214.63	\$511.58	\$502.76	\$311.65	\$311.65	\$779.13	\$779.13
40-49	\$241.09	\$235.21	\$476.30	\$461.60	\$370.45	\$370.45	\$782.07	\$782.07
50-59	\$320.47	\$267.55	\$558.62	\$543.92	\$473.36	\$473.36	\$870.27	\$870.27
60-65+	\$446.90	\$505.70	\$761.49	\$832.05	\$567.44	\$567.44	\$999.63	\$999.63

FEBRUARY 2007

	SINGLE		PARENT/CHILD(REN)		HUSBAND/WIFE		FAMILY	
	Male	Female	Male	Female	Male	Female	Male	Female
<25-29	\$157.07	\$171.88	\$646.04	\$675.68	\$248.93	\$248.93	\$812.00	\$812.00
30-39	\$183.74	\$216.34	\$515.65	\$506.76	\$314.13	\$314.13	\$785.33	\$785.33
40-49	\$243.01	\$237.08	\$480.09	\$465.27	\$373.40	\$373.40	\$788.29	\$788.29
50-59	\$323.02	\$269.68	\$563.07	\$548.25	\$477.12	\$477.12	\$877.20	\$877.20
60-65+	\$450.45	\$509.72	\$767.55	\$838.67	\$571.96	\$571.96	\$1,007.59	\$1,007.59

