

New Jersey Indemnity Summary of Coverage



	Plan A/50	Plan B	Plan C	Plan D
Provisions				
Eligibility	Not eligible for Medicare or group coverage that provides the same or similar coverage; no "actively at work" required, unmarried child under 19 (or up to 23 if enrolled in an accredited school)	Not eligible for Medicare or group coverage that provides the same or similar coverage; no "actively at work" required, unmarried child under 19 (or up to 23 if enrolled in an accredited school)	Not eligible for Medicare or group coverage that provides the same or similar coverage; no "actively at work" required, unmarried child under 19 (or up to 23 if enrolled in an accredited school)	Not eligible for Medicare or group coverage that provides the same or similar coverage; no "actively at work" required, unmarried child under 19 (or up to 23 if enrolled in an accredited school)
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Deductible - SINGLE - FAMILY¹	\$1,000, \$2,500, \$5,000, \$10,000 \$2,000, \$5,000, \$10,000, \$20,000	\$1,000, \$2,500 \$2,000, \$5,000	\$1,000, \$2,500 \$2,000, \$5,000	\$1,000, \$2,500 \$2,000, \$5,000
Coinsurance/MOOP***	50% up to \$6,000 single, \$12,000 family; 100% thereafter per calendar year, subject to usual and customary rates (UCR)	40% up to \$4,000 single, \$8,000 family; 100% thereafter per calendar year, subject to usual and customary rates (UCR)	30% up to \$3,500 single, \$7,000 family; 100% thereafter per calendar year, subject to usual and customary rates (UCR)	20% up to \$3,000 single, \$6,000 family; 100% thereafter per calendar year, subject to usual and customary rates (UCR)
Additional Inpatient Hospital Deductible*	Subject to above, no additional	Subject to above, no additional	Subject to above, no additional	Subject to above, no additional
Emergency Room	\$100 per visit per covered person; credited toward inpatient if admitted within 24 hours*	\$100 per visit per covered person; credited toward inpatient if admitted within 24 hours*	\$100 per visit per covered person; credited toward inpatient if admitted within 24 hours*	\$100 per visit per covered person; credited toward inpatient if admitted within 24 hours*
Alcoholism	Treated the same as any illness	Treated the same as any illness	Treated the same as any illness	Treated the same as any illness
Home Healthcare	365 days, if preapproved per calendar year	365 days, if preapproved per calendar year	365 days, if preapproved per calendar year	365 days, if preapproved per calendar year
Hospice	Unlimited if preapproved	Unlimited if preapproved	Unlimited if preapproved	Unlimited if preapproved
Skilled Nursing Facility	120 days if preapproved per calendar year	120 days if preapproved per calendar year	120 days if preapproved per calendar year	120 days if preapproved per calendar year
Non-Biologically Based Mental Health/Substance Abuse (at approved facilities only)**	Inpatient - 30 day limit Outpatient - 20 visit limit	Inpatient - 30 day limit Outpatient - 20 visit limit	Inpatient - 30 day limit Outpatient - 20 visit limit	Inpatient - 30 day limit Outpatient - 20 visit limit
Prescription Drugs	Subject to deductible and coinsurance; includes insulin needles/syringes, oral contraceptives	Subject to deductible and coinsurance; includes insulin needles/syringes, oral contraceptives	Subject to deductible and coinsurance; includes insulin needles/syringes, oral contraceptives	Subject to deductible and coinsurance; includes insulin needles/syringes, oral contraceptives

New Jersey Indemnity Summary of Coverage



Provisions	Plan A/50	Plan B	Plan C	Plan D
Preventive Services	\$500 for single, newborns \$750 for first year; not subject to deductibles or coinsurance	\$500 for single, newborns \$750 for first year; not subject to deductibles or coinsurance	\$500 for single, newborns \$750 for first year; not subject to deductibles or coinsurance	\$500 for single, newborns \$750 for first year; not subject to deductibles or coinsurance
Therapy	30 visits per calendar year per person per therapy; physical, occupational, speech, and cognitive rehabilitation	30 visits per calendar year per person per therapy; physical, occupational, speech, and cognitive rehabilitation	30 visits per calendar year per person per therapy; physical, occupational, speech, and cognitive rehabilitation	30 visits per calendar year per person per therapy; physical, occupational, speech, and cognitive rehabilitation
Therapeutic Manipulations	30 visits per calendar year	30 visits per calendar year	30 visits per calendar year	30 visits per calendar year
Infertility	Excluded	Excluded	Excluded	Excluded
Orthotics and Prosthetics	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Durable Medical Equipment	Coverage for rental when preapproved (we may purchase if we choose; no repairs or replacements)	Coverage for rental when preapproved (we may purchase if we choose; no repairs or replacements)	Coverage for rental when preapproved (we may purchase if we choose; no repairs or replacements)	Coverage for rental when preapproved (we may purchase if we choose; no repairs or replacements)
Transplants	Subject to utilization review & preapproval	Subject to utilization review & preapproval	Subject to utilization review & preapproval	Subject to utilization review & preapproval
Additional Exclusions	Eye exams; see policy for list	Eye exams; see policy for list	Eye exams; see policy for list	Eye exams; see policy for list
Chemotherapy/Radiation Chelation, Dialysis, and Respiration Therapy	Covered as any other illness subject to preapproval	Covered as any other illness subject to preapproval	Covered as any other illness subject to preapproval	Covered as any other illness subject to preapproval

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.

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

** You may be able to exchange one (1) inpatient day for two (2) outpatient visits. This exchange requires **preapproval**. You must call Oxford at 800-767-3840 at least 14 days in advance of treatment to request precertification.

*** Deductible and coinsurance per calendar year are subject to Reasonable & Customary fees.

Please note: This is intended only as a general summary of benefits. All benefits are subject to terms of your indemnity policy. More complete descriptions of benefits and the terms under which they are provided, including limitations and exclusions, are contained in your policy.

NJ Individual Indemnity Plan A/50 Rates - \$2,500 DEDUCTIBLE

August 2009 - October 2009



AUGUST 2009

	SINGLE	PARENT/CHILD(REN)	HUSBAND/WIFE	FAMILY
<25	\$296.18	\$698.85	\$616.80	\$1,119.56
25-29	\$331.10	\$733.76	\$688.38	\$1,176.58
30-34	\$385.79	\$789.04	\$803.01	\$1,275.50
35-39	\$419.54	\$822.21	\$872.25	\$1,345.33
40-44	\$463.18	\$865.85	\$963.03	\$1,427.38
45-49	\$488.21	\$890.87	\$1,015.40	\$1,490.22
50-54	\$555.12	\$957.79	\$1,154.47	\$1,620.56
55-59	\$637.17	\$1,039.84	\$1,324.96	\$1,792.22
60-64	\$744.24	\$1,146.91	\$1,548.41	\$2,001.70
65+	\$783.81	\$1,186.47	\$1,629.87	\$2,071.53

SEPTEMBER 2009

	SINGLE	PARENT/CHILD(REN)	HUSBAND/WIFE	FAMILY
<25	\$299.22	\$706.01	\$623.12	\$1,131.02
25-29	\$334.49	\$741.28	\$695.43	\$1,188.63
30-34	\$389.74	\$797.12	\$811.23	\$1,288.57
35-39	\$423.84	\$830.63	\$881.19	\$1,359.11
40-44	\$467.93	\$874.72	\$972.89	\$1,442.00
45-49	\$493.21	\$900.00	\$1,025.80	\$1,505.48
50-54	\$560.81	\$967.60	\$1,166.29	\$1,637.16
55-59	\$643.70	\$1,050.49	\$1,338.53	\$1,810.58
60-64	\$751.86	\$1,158.65	\$1,564.27	\$2,022.20
65+	\$791.83	\$1,198.63	\$1,646.57	\$2,092.75

OCTOBER 2009

	SINGLE	PARENT/CHILD(REN)	HUSBAND/WIFE	FAMILY
<25	\$302.28	\$713.24	\$629.50	\$1,142.61
25-29	\$337.91	\$748.87	\$702.55	\$1,200.81
30-34	\$393.74	\$805.29	\$819.54	\$1,301.76
35-39	\$428.18	\$839.14	\$890.21	\$1,373.03
40-44	\$472.72	\$883.68	\$982.85	\$1,456.76
45-49	\$498.26	\$909.21	\$1,036.30	\$1,520.90
50-54	\$566.55	\$977.51	\$1,178.24	\$1,653.93
55-59	\$650.29	\$1,061.25	\$1,352.24	\$1,829.12
60-64	\$759.56	\$1,170.52	\$1,580.29	\$2,042.91
65+	\$799.94	\$1,210.90	\$1,663.43	\$2,114.18

NJ Individual Indemnity Plan A/50 Rates - \$2,500 DEDUCTIBLE

November 2009 - January 2010



NOVEMBER 2009

	SINGLE	PARENT/CHILD(REN)	HUSBAND/WIFE	FAMILY
<25	\$305.37	\$720.54	\$635.95	\$1,154.30
25-29	\$341.37	\$756.54	\$709.74	\$1,213.10
30-34	\$397.77	\$813.53	\$827.93	\$1,315.09
35-39	\$432.56	\$847.73	\$899.33	\$1,387.08
40-44	\$477.56	\$892.73	\$992.92	\$1,471.68
45-49	\$503.36	\$918.52	\$1,046.91	\$1,536.47
50-54	\$572.35	\$987.52	\$1,190.30	\$1,670.86
55-59	\$656.95	\$1,072.11	\$1,366.09	\$1,847.85
60-64	\$767.34	\$1,182.50	\$1,596.47	\$2,063.83
65+	\$808.13	\$1,223.30	\$1,680.46	\$2,135.82

DECEMBER 2009

	SINGLE	PARENT/CHILD(REN)	HUSBAND/WIFE	FAMILY
<25	\$308.50	\$727.91	\$642.46	\$1,166.12
25-29	\$344.87	\$764.28	\$717.00	\$1,225.51
30-34	\$401.84	\$821.86	\$836.40	\$1,328.55
35-39	\$436.99	\$856.41	\$908.53	\$1,401.28
40-44	\$482.45	\$901.86	\$1,003.08	\$1,486.74
45-49	\$508.51	\$927.92	\$1,057.63	\$1,552.20
50-54	\$578.21	\$997.62	\$1,202.48	\$1,687.96
55-59	\$663.67	\$1,083.08	\$1,380.07	\$1,866.76
60-64	\$775.19	\$1,194.60	\$1,612.81	\$2,084.95
65+	\$816.40	\$1,235.82	\$1,697.66	\$2,157.68

JANUARY 2010

	SINGLE	PARENT/CHILD(REN)	HUSBAND/WIFE	FAMILY
<25	\$311.66	\$735.36	\$649.03	\$1,178.05
25-29	\$348.39	\$772.10	\$724.34	\$1,238.05
30-34	\$405.95	\$830.27	\$844.96	\$1,342.14
35-39	\$441.46	\$865.17	\$917.82	\$1,415.61
40-44	\$487.38	\$911.09	\$1,013.34	\$1,501.95
45-49	\$513.71	\$937.42	\$1,068.45	\$1,568.07
50-54	\$584.12	\$1,007.83	\$1,214.78	\$1,705.23
55-59	\$670.46	\$1,094.16	\$1,394.18	\$1,885.85
60-64	\$783.12	\$1,206.82	\$1,629.30	\$2,106.28
65+	\$824.75	\$1,248.46	\$1,715.02	\$2,179.75