

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 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
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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
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Hospice Care

Unlimited Days, if Pre approved	Subject to deductible & coinsurance	Subject to deductible & coinsurance
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Prescription Drugs

Per Generic/Brand Name Prescription	50% coinsurance	None
Diabetic Supplies	Subject to deductible & coinsurance	Subject to deductible & coinsurance

Other Items

Durable Medical Equipment when Medically Necessary (requires preapproval)	Subject to deductible & coinsurance	Subject to deductible & coinsurance
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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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