2014 New Jersey Individual EPO Product General Summary of Benefits

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BENEFITS	EPO BRONZE PLAN A $2,500	EPO SILVER PLAN C $30 PCP COPAYMENT; $2,500	EPO SILVER PLAN D $30 PCP COPAYMENT; $1,500	CATASTROPHIC $6,350
Cost-Sharing				
Deductible				
Single	$2,500	$2,500	$1,500	$6,350
Family	$5,000	$5,000	$3,000	$12,700
Coinsurance	50%	30%	20%	Not applicable
Single Maximum Out-of-Pocket	$6,350	$6,350	$6,350	$6,350
Family Maximum-out-of-Pocket	$12,700	$12,700	$12,700	$12,700
Inpatient Care				
Hospital	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.	Ded.
Other Covered Charges	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.	Ded.
Emergency Care				
Ambulance Service for Medical Emergency	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.	Ded.
Emergency Room	$100 copayment then D&C	$100 copayment then D&C	$100 copayment then D&C	Ded.
Emergency Care in Urgi-Center	Ded. & Coins.	$75 copayment	$75 copayment	Ded.
Maternity Care				
Prenatal Care	No Cost-Sharing	No Cost-Sharing	No Cost-Sharing	No Cost-Sharing
Delivery - Postnatal Care and Hospital Services for Mother and Child	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.	Ded.
Outpatient Care				
Primary Care Physician Office Visits	Ded. & Coins.	$30 copayment	$30 copayment	Ded. (No Cost-Sharing for first 3 office visits)
Specialist Office Visits	Ded. & Coins.	$50 copayment	$50 copayment	Ded.
Ambulatory surgical facility	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.	Ded.
Second surgical opinion	No Cost-Sharing	No Cost-Sharing	No Cost-Sharing	Ded.
Pre-admission Testing	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.	Ded.
Magnetic Resonance Imaging (MRI)	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.	Ded.
Preventive Care	No Cost-Sharing	No Cost-Sharing	No Cost-Sharing	None
Therapy Services				
30 visits per covered person per cal. Year	Ded. & Coins.	$30 copayment	$30 copayment	Ded.
Home Health Care				
Unlimited Days, if pre-approved	Ded. & Coins.	$50 copayment	$50 copayment	Ded.
Skilled Nursing Care				
Unlimited Days, if pre-approved	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.	Ded.
Mental Illness & Substance Abuses				
Inpatient - Unlimited Days, if pre-approved	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.	Ded.
Outpatient - Unlimited Days, if pre-approved	Ded. & Coins.	$30 copayment	$50 copayment	Ded.
Therapeutic Manipulation				
30 visits per calendar year	Ded. & Coins.	$30 copayment	$30 copayment	Ded.
Hospice Care				
Unlimited Days, if pre-approved	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.	Ded.
Prescription Drugs				
Separate Drug Deductible	Subject to medical deductible	Not applicable	$250	Subject to medical deductible
Per Generic/Brand Name Prescription	50% Coins. (after medical ded.)	50% Coins.	50% Coins. (after Rx ded.)	100% covered (after medical ded.)

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2014 New Jersey Individual HMO Product General Summary of Benefits

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BENEFITS	HMO GOLD	HMO PLATINUM
Cost-Sharing		
Deductible	N/A	N/A
Single Maximum Out-of-Pocket	$5,000	$1,200
Family Out-of-Pocket Maximum	$10,000	$2,400
Inpatient Care		
Hospital	$500 copayment per day,	$300 copayment per day,
Other Covered Charges	5 day maximum per admission ($5,000 maximum per year)	4 day maximum per admission ($1,200 maximum per year)
Emergency Care		
Ambulance Service for Medical Emergency	No Cost-Sharing	No Cost-Sharing
Emergency Room	$100 copayment	$100 copayment
Emergency Care in Urgi-Center	$80 copayment	$80 copayment
Maternity Care		
Prenatal Care	No Cost-Sharing	No Cost-Sharing
Delivery - Postnatal Care and Hospital Services for Mother and Child	Included as part of Inpatient Hospital Service Cost-Sharing	Included as part of Inpatient Hospital Service Cost-Sharing
Outpatient Care		
Primary Care Physician Office Visits	$30 copayment	$30 copayment
Specialist Office Visits	$60 copayment	$60 copayment
Ambulatory surgical facility	$250 copayment	$150 copayment
Second surgical opinion	$60 copayment	$60 copayment
Pre-admission Testing	$30 copayment	$30 copayment
Magnetic Resonance Imaging (MRI)	$100 copayment	$100 copayment
Preventive Care	No Cost-Sharing	No Cost-Sharing
Therapy Services		
30 visits per covered person per cal. Year	$30 copayment	$30 copayment
Home Health Care		
Unlimited Days, if pre-approved	No Cost-Sharing	No Cost-Sharing
Skilled Nursing Care		
Unlimited Days, if pre-approved	No Cost-Sharing	No Cost-Sharing
Mental Illness & Substance Abuses		
Inpatient - Unlimited Days, if pre-approved	$500 copayment per day, 5 day maximum per admission ($5,000 maximum per year)	$300 copayment per day, 4 day maximum per admission ($1,200 maximum per year)
Outpatient - Unlimited Days, if pre-approved	$60 copayment	$60 copayment
Therapeutic Manipulation		
30 visits per calendar year	$30 copayment	$30 copayment
Hospice Care		
Unlimited Days, if pre-approved	No Cost-Sharing	No Cost-Sharing
Prescription Drugs		
Separate Drug Deductible	$250	$125
Per Generic/Brand Name Prescription	50% coinsurance (after Rx ded.)	50% coinsurance (after Rx ded.)

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