

**SOMERSET HOME FOR TEMPORARILY DISPLACED CHILDREN**  
**Horizon Blue Cross/Blue Shield**  
**Plans-Premiums-Employee Contribution**  
**April 2010 Renewal**

	Single	Parent/Child(s)	2 Adults	Family
<b>Plan 00 (2010)</b> <b>Basic Plan</b> <b>Direct Access Advantage</b>	<b>\$30 PCP/\$50 Spec Co-pay per Office Visit</b> <b>Deductible: \$2,500 In Network/\$5,000 Out of Network</b> <b>100%/80%/60% Co-insurance</b> <b>Hospital: 80% In Network/60% Out of Network after Deductible</b> <b>In network Max \$4,000/\$10,000 Out of Network Max</b> <b>Rx Card: \$15/\$40/\$75 *</b>			
Monthly Premium	\$ 334.12	\$ 567.42	\$ 699.04	\$ 951.48
Employee Contribution	\$ -	\$ 233.30	\$ 364.92	\$ 617.36
<b>Ee Per Pay Contribution</b>	<b>\$ -</b>	<b>\$ 107.68</b>	<b>\$ 168.42</b>	<b>\$ 284.94</b>

<b>Plan 01 (2010)</b> <b>Direct Access</b>	<b>\$30 Co-pay per Office Visit</b> <b>\$1,500 Deductible (In &amp; Out of Network)</b> <b>100%/80%/60% Co-insurance</b> <b>Hospital: 80% In Network/60 % Out of Network after Deductible</b> <b>In network Max \$3,500/\$5,250 Out of Network Max</b> <b>Rx Card: \$15/\$40/\$75 *</b>			
Monthly Premium	\$ 443.90	\$ 765.59	\$ 932.77	\$ 1,281.87
Employee Contribution	\$ 109.78	\$ 431.47	\$ 598.65	\$ 947.75
<b>Ee Per Pay Contribution</b>	<b>\$ 50.67</b>	<b>\$ 199.14</b>	<b>\$ 276.30</b>	<b>\$ 437.42</b>

<b>Plan 02 (2010)</b> <b>Horizon HMO</b> <b>MUST CHOOSE PCP</b> <b>REQUIRES REFERRALS</b> <b>MUST USE IN NETWORK PROVIDERS</b>	<b>\$30 Co-pay per Office Visit</b> <b>No Deductible In Network</b> <b>100% Co-insurance In Network</b> <b>Hospital: 100% In Network</b> <b>Rx Card: \$10/\$35/\$70 Rx Card **</b>			
Monthly Premium	\$ 473.58	\$ 814.14	\$ 994.22	\$ 1,363.56
Employee Contribution	\$ 139.46	\$ 480.02	\$ 660.10	\$ 1,029.44
<b>Ee Per Pay Contribution</b>	<b>\$ 64.37</b>	<b>\$ 221.55</b>	<b>\$ 304.66</b>	<b>\$ 475.13</b>

**THERE IS A FINANCIAL INCENTIVE TO PURCHASE YOUR PRESCRIPTIONS BY MAIL**

	<u>Retail - 30 Days Supply</u>	<u>Mail Order - 90 Days Supply</u>
* <b>Generic</b>	<b>\$15</b>	<b>\$30</b>
<b>Prefered (Formulary)</b>	<b>\$40</b>	<b>\$100</b>
<b>Name Brand</b>	<b>\$75</b>	<b>\$200</b>
	<u>Retail - 30 Days Supply</u>	<u>Mail Order - 90 Days Supply</u>
** <b>Generic</b>	<b>\$10</b>	<b>\$20</b>
<b>Prefered (Formulary)</b>	<b>\$35</b>	<b>\$70</b>
<b>Name Brand</b>	<b>\$70</b>	<b>\$140</b>



Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work<sup>®</sup>

# Horizon Advantage Direct Access

## 100%/80%/60%

### Benefit Highlight (effective 4/01/2010)

Office Visit Copayment	Deductible		Maximum Out of Pocket	
	Network	Out-of-Network	Network	Out-of-Network
\$30/\$50	\$2,500	\$5,000	\$4,000	\$10,000

Family Deductible and Maximum out of Pocket are two times the individual amount.

Maximum Out of Pocket is calendar year. The deductible, coinsurance and copayments apply to the Maximum Out of Pocket.

Benefit	In-Network	Out-of-Network
Benefit Period Maximum	Unlimited	Unlimited
Lifetime Maximum	Unlimited	Unlimited
Primary Care Physician Selection	Not Required	

#### Doctor's Office Visits

Primary Care Office Visit	100% after copayment	60% after deductible
	A Primary Care Physician (PCP) is a general or family practitioner, internist or pediatrician.	
Specialist Office Visit	100% after copayment	60% after deductible
	A referral is not required to visit a specialist.	
Maternity Visits (Total obstetrical care includes pre/post-natal visits and delivery)	100% after copayment \$25 copayment per pregnancy for initial visit only	60% after deductible
Allergy Testing and Treatment	100% after copayment	60% after deductible
Preventive Care	100% after copayment	100%
	\$750 maximum per covered dependent child through end of calendar year in which child turns one. \$500 maximum per covered person per calendar year. Not subject to deductible or coinsurance.	

#### Diagnostic Procedures

Laboratory	100% when provided by a participating laboratory	60% after deductible
Outpatient X-ray/Radiology Services	100% when provided by a participating radiologist	60% after deductible

CT/CTA Scans, Pet Scans, MRIs/MRAs, Nuclear Medicine studies (including Nuclear Cardiology) require prior authorization. The ordering physician should request the prior authorization by calling CareCore National, LLC (CCN) at **1-866-496-6200** and providing the necessary clinical information. Once the authorization number is received, the member may call CCN at **1-866-969-1234** to schedule an appointment.

*Note: Managed Care members can call **1-866-969-1234** to obtain a confirmation number for non-Advanced Imaging diagnostic procedures. Confirmation numbers from CCN replace the need for a paper referral.*

Office Visit Copayment	Deductible		Maximum Out of Pocket	
	Network	Out-of-Network	Network	Out-of-Network
\$30/\$50	\$2,500	\$5,000	\$4,000	\$10,000
<p align="center"><b>Family Deductible and Maximum out of Pocket are two times the individual amount.</b>  <b>Maximum Out of Pocket is calendar year. The deductible, coinsurance and copayments apply to the Maximum Out of Pocket.</b></p>				
Benefit	In-Network	Out-of-Network		
<b>Inpatient Care</b>				
Inpatient Hospital Services (including maternity) Room & Board is for a semi-private room or intensive care. All inpatient admissions require prior authorization from Horizon BCBSNJ.	80% after deductible	60% after deductible		
Pre-admission testing	80% after deductible	60% after deductible		
Inpatient Physician Services	80% after deductible	60% after deductible		
<b>Emergency Care</b>				
Emergency Room copayment waived if admitted within 24 hours	\$100 copayment then 80% coinsurance. No deductible applies to the Emergency Room facility charges.	\$100 copayment then deductible and 60% coinsurance apply.		
Ambulance	80% after deductible Pre-approval required on non-emergency transportation.	60% after deductible		
<b>Outpatient Care</b>				
Outpatient Hospital Services	80% after deductible	60% after deductible		
Outpatient Physician Services	80% after deductible	60% after deductible		
Ambulatory SurgiCenter (ASC)	80% after deductible	60% after deductible Limited to a \$2,000 maximum per person per calendar year.		
ASC Physician Services	80% after deductible	60% after deductible		
<b>Mental Health Services</b>				
Inpatient Biologically Based Mental Illness	80% after deductible	60% after deductible		
Outpatient Biologically Based Mental Illness	Office - 100% after copayment Outpatient facility - 80% after deductible	Office - 60% after deductible Other - 60% after deductible		
Inpatient Non-Biologically Based Mental Illness/Drug Abuse	80% after deductible Limited to 30 inpatient days per calendar year combined. One inpatient day may be exchanged for two outpatient visits. (Requires pre-approval)	60% after deductible		
Outpatient Non-Biologically Based Mental Illness/Drug Abuse	80% after deductible Limited to 20 outpatient days per calendar year combined. One inpatient day may be exchanged for two outpatient visits. (Requires pre-approval)  All Inpatient Non-Biologically Based Mental Health/ Substance Abuse Services must be coordinated through Magellan Behavioral Health at <b>1-800-626-2212</b> .	60% after deductible		

Office Visit Copayment	Deductible		Maximum Out of Pocket	
	Network	Out-of-Network	Network	Out-of-Network
\$30/\$50	\$2,500	\$5,000	\$4,000	\$10,000
<p align="center"><b>Family Deductible and Maximum out of Pocket are two times the individual amount.</b>  <b>Maximum Out of Pocket is calendar year. The deductible, coinsurance and copayments apply to the Maximum Out of Pocket.</b></p>				
Benefit	In-Network		Out-of-Network	
<b>Alcohol Abuse Services</b>				
Inpatient	80% after deductible		60% after deductible	
Outpatient department	80% after deductible		60% after deductible	
Office setting	100% after copayment		60% after deductible	
	Alcohol abuse is treated the same as any other illness.			
<b>Other Services</b>				
Bariatric Surgery (Requires pre-approval)	80% after deductible		60% after deductible	
Diabetic Education	80% after deductible		60% after deductible	
Diabetic Supplies	80% after deductible		60% after deductible	
Durable Medical Equipment	50% coinsurance		50% after deductible	
	Combined limit of \$2,500 per person per calendar year.			
Orthotics & Prosthetics (per NJ mandate)	100% after copayment		60% after deductible	
Home Health Care - Limited to 60 visit maximum per person per calendar year.	80% after deductible Requires pre-approval		60% after deductible Requires pre-approval	
Hospice Care	80% after deductible Requires pre-approval		60% after deductible Requires pre-approval	
Infertility <i>Certain fertility services are excluded.</i>	100% after copayment in office 80% after deductible for all other requires pre-approval		Office - 60% after deductible Other - 60% after deductible Requires pre-approval	
Speech & Cognitive 30 visit limit combined per year	Office - 100% after copayment Other - 80% after deductible		Office - 60% after deductible Other - 60% after deductible	
Physical, Occupational 30 visit limit combined per year	Office - 100% after copayment Other - 80% after deductible		Office - 60% after deductible Other - 60% after deductible	
Skilled Nursing Facility/ Extended Care Center	80% after deductible 120 days per calendar year  Must begin within 14 days of preceding hospital stay. Requires pre-approval.		60% after deductible 120 days per calendar year	
Therapeutic Manipulation 30 visit maximum per calendar year	Office - 100% after copayment Other - 80% after deductible		Office - 60% after deductible Other - 60% after deductible	
Vision Screening (Vision exams are not covered, only preventive care screenings for child dependent up to age 17 in your pediatrician's office).	100% after copayment		60% after deductible	

Office Visit Copayment	Deductible		Maximum Out of Pocket	
	Network	Out-of-Network	Network	Out-of-Network
\$30/\$50	\$2,500	\$5,000	\$4,000	\$10,000

Family Deductible and Maximum out of Pocket are two times the individual amount.  
Maximum Out of Pocket is calendar year. The deductible, coinsurance and copayments apply to the Maximum Out of Pocket.

Benefit	In-Network	Out-of-Network
<b>Other Services (cont'd.)</b>		
Vision Hardware	Not covered	Not covered
Prescription Drugs Prescription Card: \$15/\$40/\$75 Refer to Prescription Plan Options - Plan 00 & 01	<b>COPAYMENT:</b> Generic \$15 Brand-Preferred \$40 Brand-Non-Preferred \$75	<b>RETAIL</b> \$15 \$40 \$75  <b>MAIL ORDER</b> \$30 \$100 \$200
Eligibility	Coverage for dependents include unmarried children under the age of 19. Full-time students who are enrolled at an accredited school are covered until the day in which he or she turns 23 years of age.	
Pre-Existing Conditions	A pre-existing condition is a medical condition diagnosed or treated in the six months prior to the effective date of coverage. This applies to groups of two to five eligible employees and to late enrollees in groups of six or more (those not enrolling within 30 days of being eligible). Prior coverage may be credited toward satisfying the pre-existing condition limitation if that coverage did not lapse more than 90 days prior to the effective date.	
Prior Authorization	Some services/procedures require prior authorization. For a complete list, contact member services at <b>1-800-355-BLUE (2583)</b> or refer to <a href="http://www.HorizonBlue.com">www.HorizonBlue.com</a> .	

You can save money when you choose to receive care from health care professionals that participate in the Horizon BCBSNJ networks. When you use participating hospitals or other medical facilities or physicians, you generally only pay your copayment and any applicable in-network coinsurance or deductible. If you have services performed at an out-of-network facility or by an out of network provider, your out-of-network benefits will apply. This means that you will be responsible for amounts exceeding Horizon BCBSNJ's allowable reimbursement for that particular service and this may result in significant out-of-pocket costs. You will be responsible to pay this amount directly to the nonparticipating hospital, ambulatory surgery center or provider. By using our Horizon BCBSNJ network health care professionals, you keep your health care costs down.

This summary highlights the major features of your health benefit program. It is not a contract and some limitations and exclusions may apply. Payment of benefits is subject solely to the terms of the contract. Please refer to your benefit booklet for more information.

**Additional Information:**

- We will continue to renew coverage at the option of the plan sponsor except for the following reasons:  
Nonpayment of premiums, fraud, violation of contribution or participation rules, withdrawal of this plan from the marketplace or the lack of any enrollee who lives or works in the service area.
- We require the employer to contribute a minimum of 10 percent to the cost of the group health benefits plan.
- We require 75 percent of your eligible employees (those working 25 hours or more) to participate in a group plan you offer. Those covered by a spouse's group plan will count toward the 75 percent. All affiliated, subsidiary, commonly owned companies count as one company.
- A pre-existing condition is a medical condition diagnosed or treated in the six months prior to the effective date of coverage. This applies to groups of two to five eligible employees and to late enrollees in groups of six or more (those not enrolling within 30 days of being eligible). Prior coverage may be credited toward satisfying the pre-existing condition limitation if that coverage did not lapse more than 90 days prior to the effective date.
- Our service area spans all 21 counties of New Jersey: Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union and Warren.

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27155 (W1109)



Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.

# Horizon Direct Access

## 100/80/60

### Benefit Highlight

Office Visit Copayment	Deductible	Maximum Out of Pocket	
		Network	Out-of-Network
\$30	\$1,500	\$3,500	\$5,250

Family deductible and maximum out of pocket (MOOP) are two times the individual amount. MOOP is calendar year. The deductible, coinsurance and copayments apply to the MOOP. Prescription copayments do not apply towards the MOOP.

Benefit	In-Network	Out-of-Network
<b>Benefit Period Maximum</b>	Unlimited	Unlimited
<b>Lifetime Maximum</b>	Unlimited	Unlimited
<b>Primary Care Physician Selection</b>	Not Required	
<b>Doctor's Office Visits</b>		
Physician Office Visit	100% after copayment	60% after deductible
	A Primary Care Physician (PCP) is a general or family practitioner, internist or pediatrician.	
Specialist Office Visit	100% after copayment	60% after deductible
	A referral is not required to visit a specialist.	
Maternity Visits (Total obstetrical care includes pre/post-natal visits and delivery)	100% after copayment for initial visit only	60% after deductible
Allergy Testing and Treatment	100% after copayment	60% after deductible
Preventive Care	100% after copayment	100%
	\$750 maximum per covered dependent child through end of calendar year in which child turns one. \$500 maximum per covered person per calendar year. Not subject to deductible or coinsurance.	
<b>Diagnostic Procedures</b>		
Laboratory	100% when provided by a participating laboratory	60% after deductible
Outpatient X-ray/Radiology Services	100% when provided by a participating radiologist	60% after deductible

Office Visit Copayment	Deductible	Maximum Out of Pocket Network	Maximum Out of Pocket Out-of-Network
\$30	\$1,500	\$3,500	\$5,250

Family deductible and maximum out of pocket (MOOP) are two times the individual amount. MOOP is calendar year. The deductible, coinsurance and copayments apply to the MOOP. Prescription copayments do not apply towards the MOOP.

Benefit	In-Network	Out-of-Network
<b>Inpatient Care</b>		
Inpatient Hospital Services (including maternity). Room and board is for a semi-private room or intensive care. All inpatient admissions require prior authorization from Horizon BCBSNJ.	80% after deductible	60% after deductible \$200 copayment per day \$1,000 maximum copayment per confinement \$2,000 maximum copayment per calendar year per person
Pre-admission testing	80% after deductible	60% after deductible
Inpatient Physician Services	80% after deductible	60% after deductible
<b>Emergency Care</b>		
Emergency Room copayment waived if admitted within 24 hours	\$50 copayment then 80% coinsurance	\$50 copayment then deductible and 60% coinsurance apply
Ambulance	80% after deductible	60% after deductible
<b>Outpatient Care</b>		
Outpatient Hospital Services	80% after deductible	60% after deductible
Outpatient/ASC Physician Services	80% after deductible	60% after deductible
Ambulatory SurgiCenter (ASC)	80% after deductible	60% after deductible
<b>Mental Health Services</b>		
Inpatient Biologically Based Mental Illness	80% after deductible	60% after deductible \$200 copayment per day \$1,000 maximum copayment per confinement \$2,000 maximum copayment per calendar year per person
Outpatient Biologically Based Mental Illness	Office - 100% after copayment Outpatient facility - 80% after deductible	Office - 60% after deductible Other - 60% after deductible
Inpatient Non-Biologically Based Mental Illness/Drug Abuse	80% after deductible	60% after deductible \$200 copayment per day \$1,000 maximum copayment per confinement \$2,000 maximum copayment per calendar year per person
	Limited to 30 outpatient days per calendar year combined. One inpatient day may be exchanged for two outpatient visits. Requires pre-approval	

Office Visit Copayment	Deductible	Maximum Out of Pocket Network	Maximum Out of Pocket Out-of-Network
\$30	\$1,500	\$3,500	\$5,250

Family deductible and maximum out of pocket (MOOP) are two times the individual amount. MOOP is calendar year. The deductible, coinsurance and copayments apply to the MOOP. Prescription copayments do not apply towards the MOOP.

Benefit	In-Network	Out-of-Network
<b>Mental Health Services (cont'd.)</b>		
Outpatient Non-Biologically Based Mental Illness/Drug Abuse	80% after deductible	60% after deductible
	Limited to 20 outpatient days per calendar year combined. One inpatient day may be exchanged for two outpatient visits. Requires pre-approval	
	All Inpatient Non-Biologically Based Mental Health/Substance Abuse Services must be coordinated through Magellan Behavioral Health at <b>1-800-626-2212</b> .	
<b>Alcohol Abuse Services</b>		
Inpatient	80% after deductible	60% after deductible
Outpatient Department	80% after deductible	60% after deductible
Office Setting	100% after copayment	60% after deductible
	Alcohol abuse is treated the same as any other illness.	
<b>Other Services</b>		
Bariatric Surgery Requires pre approval	80% after deductible	60% after deductible
Diabetic Education	80% after deductible	60% after deductible
Diabetics Supplies	80% after deductible Requires pre-approval	60% after deductible Requires pre-approval
Durable Medical Equipment	Office - 100% coinsurance Other - 80% after deductible Requires pre-approval	Office - 60% after deductible Other - 60% after deductible Requires pre-approval
Orthotics and Prosthetics (per New Jersey mandate)	100% after copayment	60% after deductible
Home Health Care	80% after deductible Requires pre-approval	60% after deductible Requires pre-approval
Hospice Care	80% after deductible Requires pre-approval	60% after deductible Requires pre-approval
Infertility Certain fertility services are excluded	Office - 100% Other - 80% after deductible Requires pre-approval	Office - 60% after deductible Other - 60% after deductible Requires pre-approval
Speech and Cognitive 30-visit limit combined per year	Office - 100% after copayment Other - 80% after deductible	Office - 60% after deductible Other - 60% after deductible
Physical, Occupational 30-visit limit combined per year	Office - 100% after copayment Other - 80% after deductible	Office - 60% after deductible Other - 60% after deductible

Office Visit Copayment	Deductible	Maximum Out of Pocket Network	Maximum Out of Pocket Out-of-Network
\$30	\$1,500	\$3,500	\$5,250

Family deductible and maximum out of pocket (MOOP) are two times the individual amount. MOOP is calendar year. The deductible, coinsurance and copayments apply to the MOOP. Prescription copayments do not apply towards the MOOP.

Benefit	In-Network	Out-of-Network
<b>Other Services (cont'd.)</b>		
Skilled Nursing Facility/Extended Care Center	80% after deductible 120 days per calendar year	60% after deductible 120 days per calendar year
	Must begin within 14 days of preceding hospital stay. Requires pre-approval.	
Therapeutic Manipulation 30-visit maximum per calendar year	Office - 100% after copayment Other - 80% after deductible	Office - 60% after deductible Other - 60% after deductible
Vision Screening (Vision exams are not covered, only preventive care screenings for dependents up to age 17 years in his/her pediatrician's office).	100% after copayment	60% after deductible
Vision Hardware	Not covered	Not covered
Prescription Drugs  Prescription Card: \$15/\$40/\$75 Refer to Prescription Plan Options Plan 00-01	<b>COPAYMENT:</b> Generic \$15 Brand-Preferred \$40 Brand-Non-Preferred \$75	<b>RETAIL</b> \$15 \$40 \$75
Eligibility	Coverage for dependents include unmarried children under age 19 years. Full-time students who are enrolled at an accredited school are covered until the day in which he or she turns age 23 years.	
Pre-Existing Conditions	A pre-existing condition is a medical condition diagnosed or treated in the six months prior to the effective date of coverage. This applies to groups of two to five eligible employees and to late enrollees in groups of six or more (those not enrolling within 30 days of being eligible). Prior coverage may be credited toward satisfying the pre-existing condition limitation if that coverage did not lapse more than 90 days prior to the effective date.	
Prior Authorization	Some services/procedures require prior authorization. For a complete list, contact our customer services number at <b>1-800-355-BLUE (2583)</b> or refer to <a href="http://www.HorizonBlue.com">www.HorizonBlue.com</a> .	

You can save money when you choose to receive care from health care professionals who participate in the Horizon BCBSNJ networks. When you use participating hospitals or other medical facilities or physicians, you generally only pay your copayment and any applicable in-network coinsurance or deductible. If you have services performed at an out-of-network facility or by an out-of-network provider, your out-of-network benefits will apply. This means that you will be responsible for amounts exceeding Horizon BCBSNJ's allowable reimbursement for that particular service and this may result in significant out-of-pocket costs. You will be responsible to pay this amount directly to the nonparticipating hospital, ambulatory surgery center or provider. By using our Horizon BCBSNJ network of health care professionals, you keep your health care costs down.

This summary highlights the major features of your health benefit program. It is not a contract and some limitations and exclusions may apply. Payment of benefits is subject solely to the terms of the contract. Please refer to your benefit booklet for more information.

**Additional Information:**

1. We will continue to renew coverage at the option of the plan sponsor except for the following reasons: nonpayment of premiums, fraud, violation of contribution or participation rules, withdrawal of this plan from the marketplace or the lack of any enrollee who lives or works in the service area.
2. We require the employer to contribute a minimum of 10 percent to the cost of the group health benefits plan.
3. We require 75 percent of your eligible employees (those working 25 hours or more) to participate in a group plan you offer. Those covered by a spouse's group plan will count toward the 75 percent. All affiliated, subsidiary, commonly owned companies count as one company.
4. A pre-existing condition is a medical condition diagnosed or treated in the six months prior to the effective date of coverage. This applies to groups of two to five eligible employees and to late enrollees in groups of six or more (those not enrolling within 30 days of being eligible). Prior coverage may be credited toward satisfying the pre-existing condition limitation if that coverage did not lapse more than 90 days prior to the effective date.
5. Our service area spans all 21 counties of New Jersey: Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union and Warren.

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Three Penn Plaza East, Newark, New Jersey 07105

5757 (W1209)

# Somerset Home for Temporarily Displaced Children \* Plan 02

## Horizon HMO Benefit Highlights



Plan	Office Visit Copayment	Maximum Out of Pocket
Horizon HMO	\$30	\$5,000
<b>Family Maximum Out of Pocket is two times the individual amount.</b> <b>Maximum Out of Pocket is calendar year. The coinsurance and copayments apply to the Maximum Out of Pocket.</b> <b>Prescription copayments do not apply towards the Maximum Out of Pocket.</b>		
Benefit	Network	
<b>Benefit Period Maximum</b>	Unlimited	
<b>Lifetime Maximum</b>	Unlimited	
<b>Primary Care Physician Selection</b>	Required	
<b>Doctor's Office Visits</b>		
Primary Care Office Visit	100% after office visit copayment	
Specialist Office Visit	100% after office visit copayment A referral is required to visit a specialist.	
Maternity Visits (Total obstetrical care includes pre/post-natal visits and delivery)	100% after \$25 copayment for initial visit only	
Allergy Testing and Treatment	100% after office visit copayment	
<b>Preventive Care</b>	100% after office visit copayment	
<b>Diagnostic Procedures</b>		
Laboratory	Office-100% \$0 copayment; Facility outpatient- 100% after office visit copayment when provided by a participating laboratory	
Outpatient X-ray/Radiology Services	Office- 100% \$0 copayment; Facility - 100% after office visit copayment	
<b>Inpatient Care</b>		
Inpatient Hospital Services (including maternity) Room & Board is for a semi-private room or intensive care. All inpatient admissions require prior authorization from Horizon BCBSNJ.  <i>*Hospital confinement rider can be purchased with this plan. If so, the hospital confinement will be waived.</i>	<b>Hospital Confinement Rider in Effect - 100% Co-insurance</b>	
Pre-admission testing	100% after office visit copayment	
Inpatient physician services	100% after hospital inpatient copayment	
<b>Emergency Care</b>		
Emergency Room Copayment waived if admitted within 24 hours	\$50 copayment	
Ambulance	100% (Requires pre-approval)	
<b>Outpatient Care</b>		
Outpatient Hospital Services	100% after office visit copayment	
Outpatient/ASC Physicians Services	100% after office visit copayment	
Ambulatory SurgiCenter (ASC)	100% after office visit copayment	
<b>Mental Health Services</b>		
Inpatient Biologically Based Mental Illness	100% after hospital inpatient copayment.	
Outpatient Biologically Based Mental Illness	100% after office visit copayment	
Inpatient Non-Biologically Based Mental Illness/Drug Abuse	100% after hospital inpatient copayment Limited to 30 inpatient days per calendar year. One inpatient day may be exchanged for two outpatient days. (Requires pre-approval)	
Outpatient Non-Biologically Based Mental Illness/Drug Abuse	100% after office visit copayment; Limited to 20 visits per calendar year.	
	All Inpatient Non-Biologically Based Mental Health/Substance Abuse Services must be coordinated through Magellan Behavioral Health at 1-800-626-2212.	
<b>Alcohol Abuse Services</b>		
Inpatient	100% after hospital inpatient copayment	
Outpatient department	100% after office visit copayment	
Office setting	100% after office visit copayment	
	Alcohol abuse is treated the same as any other illness.	
<b>Other Services</b>		
Bariatric Surgery (Requires Pre-approval)	100% after copayment	
Diabetic Education	100% after office visit copayment	
Diabetic Supplies	100% Requires pre-approval	
Durable Medical Equipment	100% Requires pre-approval	
Orthotics & Prosthetics (per NJ mandate)	100% after office visit copayment	
Home Health Care	100%-Limited to 60 visits per calendar year if pre-approved.	
Hospice Care	100%; Unlimited days if pre-approved.	
Infertility <i>Certain fertility services are excluded.</i>	100% after office visit copayment (Requires pre-approval)	



## Horizon HMO Benefit Highlights *(continued)*

Benefit	Network												
Speech & Cognitive <i>30 visit limit combined per year</i>	100% after office visit copayment												
Physical, Occupational <i>30 visit limit combined per year</i>	100% after office visit copayment												
Skilled Nursing Facility/Extended Care Center	\$0 copayment; 120 days combined if pre-approved												
Therapeutic Manipulation <i>30 visit maximum per calendar year</i>	100% after office visit copayment												
Vision Exam (Routine physical examinations, including eye exams)	100% after office visit copayment												
Vision Hardware	Not covered												
<b>Prescription Drugs</b> Prescription Card: \$10/\$30/\$70 Refer to Prescription Plan Options	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">COPAYMENT:</th> <th style="text-align: center;">RETAIL</th> <th style="text-align: center;">MAIL ORDER</th> </tr> </thead> <tbody> <tr> <td>Generic</td> <td style="text-align: center;">\$10</td> <td style="text-align: center;">\$20</td> </tr> <tr> <td>Brand-Preferred</td> <td style="text-align: center;">\$35</td> <td style="text-align: center;">\$70</td> </tr> <tr> <td>Brand-Non-Preferred</td> <td style="text-align: center;">\$70</td> <td style="text-align: center;">\$140</td> </tr> </tbody> </table>	COPAYMENT:	RETAIL	MAIL ORDER	Generic	\$10	\$20	Brand-Preferred	\$35	\$70	Brand-Non-Preferred	\$70	\$140
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Generic	\$10	\$20											
Brand-Preferred	\$35	\$70											
Brand-Non-Preferred	\$70	\$140											
<b>Eligibility</b>	Coverage for dependents include unmarried children under the age of 19. Full-time students who are enrolled at an Accredited School, are covered until the day in which he or she turns 23 years of age.												
<b>Pre-Existing Conditions</b>	A pre-existing condition is a medical condition diagnosed or treated in the six months prior to the effective date of coverage. This applies to groups of two to five eligible employees and to late enrollees in groups of six or more (those not enrolling within 30 days of being eligible). Prior coverage may be credited toward satisfying the pre-existing condition limitation if that coverage did not lapse more than 90 days prior to the effective date.												
<b>Prior Authorization</b>	Some services/procedures require prior authorization. For a complete list, contact our customer service number at <b>1-800-355-BLUE (2583)</b> or refer to <a href="http://www.HorizonBlue.com">www.HorizonBlue.com</a> .												

\* A Hospital Confinement Rider can be purchased with this plan. If so, the hospital confinement will be waived.

This summary highlights the major features of your health benefit program. It is not a contract and some limitations and exclusions may apply. Payment of benefits is subject solely to the terms of the contract. Please refer to your benefit booklet for more information.

**Additional Information:**

1. We will continue to renew coverage at the option of the plan sponsor except for the following reasons:
  - \* Nonpayment of premiums, fraud, violation of contribution or participation rules, withdrawal of this plan from the marketplace, or the lack of any enrollee who lives or works in the service area.
2. We require the employer to contribute a minimum of 10 percent to the cost of the group health benefits plan.
3. We require 75 percent of your eligible employees (those working 25 hours or more) to participate in a group plan you offer. Those covered by a spouse's group plan will count toward the 75 percent. All affiliated, subsidiary, commonly owned companies count as one company.
4. A pre-existing condition is a medical condition diagnosed or treated in the six months prior to the effective date of coverage. This applies to groups of two to five eligible employees and to late enrollees in groups of six or more (those not enrolling within 30 days of being eligible). Prior coverage may be credited toward satisfying the pre-existing condition limitation if that coverage did not lapse more than 90 days prior to the effective date.
5. Our service area spans all 21 counties of New Jersey: Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union and Warren.

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# Prescription Plan Options

**Advantage formulary applies**  
**For small employers with two to 50 eligible employees**  
**Benefit Highlights\* (Effective 4/1/10)**

## Prescription Card - Plan 00 & Plan 01

(\$15/\$40/\$75)	Retail Copayment	Mail-Order Copayment (up to a 90 day supply)
Generic-Preferred**	\$15	\$30
Brand-Preferred**	\$40	\$100
Brand-Non-Preferred**	\$75	\$200

\* **Please note:** This is not a contract. These benefit highlights are only a summary of the additional Small Employer Health (SEH) Prescription Plans offered by Horizon Blue Cross Blue Shield of New Jersey. Prescription drug plans are not available with HSA-compatible, high-deductible plan options, Horizon MSA or Horizon Comprehensive Health Plan A. This does not describe all plan designs available. If you are interested in other plan designs, please call **1-800-466-BLUE (2583)**.

\*\* Covered medications are categorized into one of the three tiers described below:

**Tier One: Generic-Preferred Drugs (lowest copayment)** - Approved by the U.S. Food and Drug Administration, generic drugs contain the same active ingredients as brand-name medications. Generics are chemically and therapeutically equivalent to brand drugs, but are available at a lower price.

**Tier Two: Brand-Preferred Drugs (middle copayment)** - These brand-name drugs have been identified as the most therapeutically safe and effective options for treatment of most medical conditions. These drugs do not have less-costly generic equivalents because they are sold under a trademarked name.

**Tier Three: Brand-Non-Preferred Drugs (highest copayment)** - These brand drugs often have either a generic equivalent or a Preferred brand drug alternative.

A prescription drug guide is available, which lists all Preferred drugs under our three-tier prescription plans. You can also visit our Web site at [www.HorizonBlue.com](http://www.HorizonBlue.com) for more information. Contact your Horizon BCBSNJ representative for more information on these prescription plans.

For complete information and verification of your benefits, refer to your group health benefits policy. In the event a conflict exists between the information contained on this benefit highlight and the actual terms of your group policy, the terms of the policy will prevail. For further information on your policy, you may call Member Services at **1-800-225-1955**. This product has exclusions beyond the standard drug plan exclusions, including drugs for weight control, erectile dysfunction, smoking cessation and acne agents. Please refer to your contract for a complete list of exclusions.

### Disclosure of information as required by the Health Insurance Portability and Accountability Act (HIPAA):

1. We will continue to renew coverage at the option of the plan sponsor except for the following reasons: nonpayment of premiums; fraud; violation of contribution or participation rules; termination of the type of plan by us; or, with respect to Health Maintenance Organization plans, movement of the employer's employees out of our service area.
2. We require the employer to contribute a minimum of 10 percent of the cost of the group health benefits plan.
3. We require 75 percent of your eligible employees (those working 25 hours or more) to participate in a group plan you offer. Those covered by a spouse's group plan will count toward the 75 percent. All affiliated, subsidiary, commonly-owned companies count as one company.
4. A pre-existing condition is an illness or injury which manifests itself in the six months before a covered person's enrollment date and medical advice, diagnosis, care or treatment was recommended or received during the six months before the enrollment date. This applies to groups of two to five eligible employees and to late enrollees in groups of six or more (those not enrolling within 30 days of being eligible). Prior coverage may be credited toward satisfying a pre-existing condition if that coverage did not lapse more than 90 days prior to the effective date.
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Horizon Blue Cross Blue Shield of New Jersey

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# Additional Prescription Plan Options

**Advantage formulary applies  
For Small Employers with two to 50 eligible employees  
Benefit Highlights\***

## Prescription Card - Plan 02

	Retail Copayment	Mail-Order Copayment
Generic-Preferred**	\$10	\$20
Brand-Preferred**	\$35	\$70
Brand-Non-Preferred**	\$70	\$140
<b>50% Coinsurance Option (payable at purchase)</b>	<b>Available for Horizon Blue Cross Blue Shield of New Jersey small employer health plans except Horizon HMO Plans.</b>	
Participating Pharmacy	Show your Horizon BCBSNJ ID card and pay 50 percent of the discounted price of the prescription. The pharmacist electronically sends the remaining 50 percent of the charges to CVS Caremark for payment to the pharmacist.	
Nonparticipating Pharmacy	You pay 100 percent of the regular prescription cost. You submit the claims to Horizon BCBSNJ and receive 50 percent reimbursement. <b>(Mail-order is not available with this option.)</b>	

\* **Please note:** This is not a contract. These benefit highlights are only a summary of the additional Small Employer Health (SEH) Prescription Plans offered by Horizon BCBSNJ. Prescription drug plans are not available with HSA-compatible, high-deductible plan options, Horizon MSA or Horizon Comprehensive Health Plan A. This does not describe all plan designs available. If you are interested in other plan designs, please call **1-800-466-BLUE (2583)**.

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**Tier One: Generic-Preferred Drugs (lowest copayment)** - Approved by the U.S. Food and Drug Administration, generic drugs contain the same active ingredients as brand-name medications. Generics are chemically and therapeutically equivalent to brand drugs, but are available at a lower price.

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A prescription drug guide is available, which lists all Preferred drugs under our three-tier prescription plans. You can also visit our Web site at [www.HorizonBlue.com](http://www.HorizonBlue.com) for more information. Contact your Horizon BCBSNJ representative for more information on these prescription plans.

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