

**SOMERSET HOME FOR TEMPORARILY DISPLACED CHILDREN**  
**Horizon Blue Cross/Blue Shield**  
**Plans-Premiums-Employee Contribution**  
**April 2009 Renewal**

Single	Parent/Child(s)	2 Adults	Family
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<b>Plan 00 (2009)</b> Basic Plan Direct Access Value Select	<b>\$30 PCP/\$50 Spec Co-pay per Office Visit</b> <b>\$2,500 Deductible (In &amp; Out of Network)</b> 100%/80%/60% Co-insurance Hospital: 80% In Network/60% Out of Network In network Max \$4,500/\$6,750 Out of Network Max <b>Rx Card: \$10/\$25/\$50 *</b>						
Monthly Premium	\$ 295.09	\$	494.24	\$	615.00	\$	829.84
Employee Contribution	\$ -	\$	199.15	\$	319.91	\$	534.75
<b>Ee Per Pay Contribution</b>	<b>\$ -</b>	<b>\$</b>	<b>91.92</b>	<b>\$</b>	<b>147.65</b>	<b>\$</b>	<b>246.81</b>

<b>Plan 01 (2009)</b> Direct Access	<b>\$30 Co-pay per Office Visit</b> <b>\$1,500 Deductible (In &amp; Out of Network)</b> 100%/80%/60% Co-insurance Hospital: 80% In Network/60 % Out of Network In network Max \$3,500/\$5,250 Out of Network Max <b>Rx Card: \$10/\$25/\$50 *</b>						
Monthly Premium	\$ 368.52	\$	626.77	\$	771.33	\$	1,050.82
Employee Contribution	\$ 73.43	\$	331.68	\$	476.24	\$	755.73
<b>Ee Per Pay Contribution</b>	<b>\$ 33.89</b>	<b>\$</b>	<b>153.08</b>	<b>\$</b>	<b>219.80</b>	<b>\$</b>	<b>348.80</b>

<b>Plan 02 (2009)</b> Horizon HMO <b>MUST CHOOSE PCP</b> <b>REQUIRES REFERRALS</b> <b>MUST USE IN NETWORK PROVIDERS</b>	<b>\$30 Co-pay per Office Visit</b> No Deductible In Network 100% Co-insurance In Network Hospital: 100% In Network <b>Rx Card: \$12/\$25/\$40 Rx Card **</b>						
Monthly Premium	\$ 411.83	\$	704.11	\$	863.25	\$	1,179.89
Employee Contribution	\$ 116.74	\$	409.02	\$	568.16	\$	884.80
<b>Ee Per Pay Contribution</b>	<b>\$ 53.88</b>	<b>\$</b>	<b>188.78</b>	<b>\$</b>	<b>262.23</b>	<b>\$</b>	<b>408.37</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>\$10</b>	<b>\$20</b>
<b>Prefered (Formulary)</b>	<b>\$25</b>	<b>\$50</b>
<b>Name Brand</b>	<b>\$50</b>	<b>\$100</b>
	<u>Retail - 30 Days Supply</u>	<u>Mail Order - 90 Days Supply</u>
** <b>Generic</b>	<b>\$12</b>	<b>\$24</b>
<b>Prefered (Formulary)</b>	<b>\$25</b>	<b>\$50</b>
<b>Name Brand</b>	<b>\$40</b>	<b>\$80</b>

## Horizon Direct Access Value Select Benefit Highlight

Office Visit Copayment	Deductible	Maximum Out of Pocket Network	Maximum Out of Pocket Non-Network
\$30/\$50	\$2,500	\$4,500	\$6,750
<b>Two deductibles per family.</b> Maximum Out of Pocket is calendar year. The deductible, coinsurance and copayments apply to the Maximum Out of Pocket. Prescription copayments do not apply towards the Maximum Out of Pocket.			
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>			
Primary Care Office Visit	100% after copayment	60% after deductible	
	A primary care physician 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)	80% after deductible \$25 copayment per pregnancy for initial visit only	60% after deductible	
Allergy Testing and Treatment	100% after copayment	60% after deductible	
<b>Preventive Care</b>			
	100% after copayment \$ 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.	100%	
<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	
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 <b>1-866-496-6200</b> and providing the necessary clinical information. Once the authorization number is received, the member may call CCN at <b>1-866-969-1234</b> to schedule an appointment.			
<i>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.</i>			
<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/ASC Physician Services	80% after deductible	60% after deductible	
Ambulatory SurgiCenter (ASC)	80% after deductible	60% after deductible	
	Services performed at a non-participating ambulatory surgery center are reimbursed at Horizon BCBSNJ's Payment Allowance and therefore may result in significant out-of-pocket costs.		
<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	60% after deductible	
	Limited to 30 inpatient days per calendar year combined. One inpatient day may be exchanged for two outpatient visits. (Requires pre-approval)		
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> .		

## Horizon Direct Access Value Select Benefit Highlight *(continued)*

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	50% coinsurance	50% 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	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% in office 80% after deductible for all other Requires pre-approval	Office- 60% after deductible Other- 60% after deductible Requires pre-approval
Speech & Cognitive <i>30 visit limit combined per year</i>	Office- 100% after copayment Other- 80% after deductible	Office- 60% after deductible Other- 60% after deductible
Physical, Occupational <i>30 visit limit combined per year</i>	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 <i>120 days per calendar year</i> Must begin within 14 days of preceding hospital stay.	60% after deductible <i>120 days per calendar year</i> Requires pre-approval.
Therapeutic Manipulation <i>30 visit maximum per benefit period</i>	Office- 100% after copayment Other- 80% after deductible	Office- 60% after deductible Other- 60% after deductible
Vision Screening- <i>(Vision exams are not covered, only preventive care screenings for child dependent up to age 17 in your pediatricians office).</i>	100% after copayment	60% after deductible
Vision Hardware	Not covered	
<b>Prescription Drugs</b> *All MMRX charges accumulate to the maximum out of pocket. <i>Other prescription options are available.</i> <i>Contact your broker or Horizon BCBSNJ representative for details.</i>	60% after deductible Prior authorization may be required	60% after deductible Prior authorization may be required
<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 <b>&lt;www.HorizonBlue.com&gt;</b> .	

You can save money when you choose to receive care from providers that participate in the Horizon BCBSNJ networks. When you use participating hospitals or other medical facilities or doctors, 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 for this amount directly to the non-participating hospital, ambulatory surgery center or provider. By using our Horizon-BCBSNJ network providers, 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.

## Horizon Direct Access 100/80/60 Benefit Highlight

Office Visit Copayment	Deductible	Maximum Out of Pocket Network	Maximum Out of Pocket Non-Network
\$10, \$20, or \$30	\$1,000	\$3,000	\$4,500
\$10, \$20, or \$30	\$1,500	\$3,500	\$5,250
\$10, \$20, or \$30	\$2,500	\$4,500	\$6,750
<b>Two deductibles per family.</b> <b>Maximum Out of Pocket is calendar year. The deductible, 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	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 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 included 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	
<b>Preventive Care</b>	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	
<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 \$200 copayment per day \$1000 maximum per confinement \$2000 maximum per calendar year	
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	
	Services performed at a non-participating ambulatory surgery center are reimbursed at Horizon BCBSNJ's Payment Allowance and therefore may result in significant out-of-pocket costs.		
<b>Mental Health Services</b>			
Inpatient Biologically Based Mental Illness	80% after deductible	60% after deductible \$200 copayment per day \$1000 maximum per stay \$2000 maximum per calendar year	
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 \$1000 maximum per stay \$2000 maximum per calendar year  Limited to 30 inpatient days per calendar year combined. One inpatient day may be exchanged for two outpatient visits. (Requires pre-approval)	
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>			

## Horizon Direct Access 100/80/60 Benefit Highlight (continued)

Benefit	In-Network	Out-of-Network
Bariatric Surgery (Requires approval)	80% after deductible	60% after deductible
Diabetic Education	80% after deductible	60% after deductible
Diabetic Supplies	80% after deductible Requires pre-approval	60% after deductible Requires pre-approval
Durable Medical Equipment	Office- 100% after copayment Other- 80% after deductible Requires pre-approval	Office- 60% after deductible Other- 60% after deductible Requires pre-approval
Orthotics & Prosthetics (per NJ 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 <i>Certain fertility services are excluded</i>	100% in office Other- 80% after deductible 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- <i>(Vision exams are not covered, only preventive care screenings for child dependent up to age 17 in your pediatricians office).</i>	100% after copayment	60% after deductible
Vision Hardware	Not covered	
<b>Prescription Drugs</b> *All MMRX charges accumulate to the maximum out of pocket. <i>Other prescription options are available.            Contact your broker or Horizon BCBSNJ representative for details.</i>	60% after deductible Prior authorization may be required	60% after deductible Prior authorization may be required
<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> .	

You can save money when you choose to receive care from providers that participate in the Horizon BCBSNJ networks. When you use participating hospitals or other medical facilities or doctors, 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 for this amount directly to the non-participating hospital, ambulatory surgery center or provider. By using our Horizon-BCBSNJ network providers, you keep your health care costs down.

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**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.



## Horizon HMO Benefit Highlights

Plan	Office Visit Copayment	Maximum Out of Pocket
<b>Horizon HMO</b>	<b>\$5, \$10, \$15, \$20 or \$30</b>	<b>\$5,000</b>
<b>Maximum Out of Pocket is calendar year. The coinsurance and copayments apply to the Maximum Out of Pocket.            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.	<b>\$5 office visit copayment</b> -\$75 hospital inpatient copayment per day; \$375 maximum per confinement; \$750 maximum per calendar year. <b>\$10 office visit copayment</b> -\$100 hospital inpatient copayment per year; \$500 maximum per confinement; \$1,000 maximum per calendar year. <b>\$15 office visit copayment</b> - \$150 hospital inpatient copayment per day; \$750 maximum per confinement; \$1,500 maximum per calendar year. <b>\$20 office visit copayment</b> -\$250 hospital inpatient copayment per day; \$1,250 maximum per confinement; \$2,500 maximum per calendar year. <b>\$30 office visit copayment</b> -\$300 hospital inpatient copayment per day; \$1,500 maximum per confinement; \$3,000 maximum per calendar year.	
<i>*Hospital confinement rider can be purchased with this plan. If so, the hospital confinement will be waived.</i>		
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 <i>(Vision exams are not covered, only preventive care screenings for child dependent up to age 17 in your pediatricians office).</i>	100% after office visit copayment
Vision Hardware	Not covered
<b>Prescription Drugs</b> All MMRx charges accumulate to the maximum out of pocket. <i>Other prescription options are available. Contact your broker or Horizon BCBSNJ representative for details.</i>	50%; Prior authorization may be required.
<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.

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**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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# Additional Prescription Plan Options

## For Small Employers with Two to 50 eligible employees Benefit Highlights\*

### Option 1

### Retail Copayment<sup>†</sup>

### Mail Order Copayment<sup>††</sup>

Generic-Preferred\*\*

\$10

\$20

Brand-Preferred\*\*

\$25

\$50

Brand-Non-Preferred\*\*

\$50

\$100

### Option 2

### Retail Copayment<sup>†</sup>

### Mail Order Copayment<sup>††</sup>

Generic-Preferred\*\*

\$10

\$20

Brand-Preferred\*\*

\$35

\$70

Brand-Non-Preferred\*\*

\$70

\$140

### Option 3

### Retail Copayment<sup>†</sup>

### Mail Order Copayment<sup>††</sup>

Generic-Preferred\*\*

\$10

\$20

Brand-Preferred\*\*

30 percent

30 percent

Brand-Non-Preferred\*\*

50 percent

50 percent

\* **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 (2585).

\*\* 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.

<sup>†</sup> Per prescription or refill up to a 30-day supply.

<sup>††</sup> Per prescription or refill up to a 90-day supply.

For complete information and verification of all your benefits, refer to your group health benefits policy. In the event a conflict exists between the information contained in these benefit highlights 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 1-800-355-BLUE (2583). This product has exclusions beyond the standard drug plan exclusions, including drugs for weight control, erectile dysfunction, smoking cessation, antihistamines, prescription vitamins 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):

- 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 plan by us or enrollees move outside the service area.
- We require the employer to contribute a minimum of 10 percent of 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 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.
- 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

For Small Employers with  
Two to 50 eligible employees

## Benefit Highlights<sup>†</sup>

### Annual Deductible Options

\$0, \$50, \$100  
(applies to \$15, \$15/\$22.50 and \$5/\$10/\$20 Rx options)

#### \$5/\$10 Rx Option

#### Retail Copayment

#### Mail Order Copayment

Generic-Preferred\* \$5  
Brand-Preferred\* \$10  
Generic/Brand-Nonpreferred\* \$10

\$5  
\$10  
\$10

\$0  
\$5  
\$5

#### \$15/\$22.50 Rx Option

#### Retail Copayment

#### Mail Order Copayment

Generic-Preferred\* \$15  
Brand-Preferred\* \$15  
Generic/Brand-Nonpreferred\* \$15

\$15  
\$15  
\$15

\$22.50  
\$22.50  
\$22.50

#### \$15 Rx Option

#### Retail Copayment

#### Mail Order Copayment

Generic-Preferred\* \$15  
Brand-Preferred\* \$15  
Generic/Brand-Nonpreferred\* \$15

\$15  
\$15  
\$15

\$0  
\$0  
\$0

#### \$5/\$10/\$20 Three-Tier Rx Option

#### Retail Copayment

#### Mail Order Copayment

Generic-Preferred\* \$5  
Brand-Preferred\* \$10  
Generic/Brand-Nonpreferred\* \$20

\$5  
\$10  
\$20

\$7.50  
\$15  
\$30

#### \$12/\$25/\$40 Three-Tier Rx Option

Available for Horizon HMO and  
Horizon HMO Coinsurance plans only.

#### Retail Copayment

#### Mail Order Copayment

Generic-Preferred\* \$12  
Brand-Preferred\* \$25  
Generic/Brand-Nonpreferred\* \$40

\$12  
\$25  
\$40

\$24  
\$50  
\$80

#### \$10/\$20/\$35 Three-Tier Rx Option

Available for Horizon POS,  
Horizon Direct Access  
and Horizon PPO plans only.

#### Retail Copayment

#### Mail Order Copayment

Generic-Preferred\* \$10  
Brand-Preferred\* \$20  
Generic/Brand-Nonpreferred\* \$35

\$10  
\$20  
\$35

\$30  
\$60  
\$105

<sup>†</sup>**Please note:** This is not a contract. This benefit highlights is only a summary of the standard Small Employer Health (SEH) Prescription Plans offered by Horizon BCBSNJ. Prescription Drug plans are not available with High Deductible Plan options, Horizon MSA or Horizon Comprehensive Health Plan A.

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

**Tier One: Preferred Generic Drugs (lowest copay)**

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: Preferred Brand Drugs (middle copay)**

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: Nonpreferred Brand Drugs (highest copay)**

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.horizon-bcbsnj.com](http://www.horizon-bcbsnj.com) for more information. Contact your Horizon BCBSNJ representative for more information on these prescription plans.



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# Prescription Plan Options

## For Small Employers with Two to 50 eligible employees

### Benefit Highlights<sup>†</sup> *continued*

**50% Coinsurance Option (payable at purchase) – Available for Horizon BCBSNJ small employer health plans except Horizon HMO plans.**

#### 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 AdvancePCS for payment to the pharmacist.

#### Nonparticipating Pharmacy

You pay 100 percent of the regular prescription cost. You submit the claim to Horizon BCBSNJ and receive 50 percent reimbursement.

**(Mail Order is not available with this option.)**

**†Please note:** This is not a contract. This benefit highlights is only a summary of the standard Small Employer Prescription Plans offered by Horizon BCBSNJ. Prescription drug plans are not available with High Deductible Plan options, Horizon MSA or Horizon Comprehensive Health Plan A.

For complete information and verification of all your benefits, refer to your group health benefits policy. In the event a conflict exists between the information contained on this benefit highlights and the actual terms of your group policy, the terms of the policy will prevail. For further information on your policy, you may also call Member Services at **1-800-225-1955**.

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 plan by us or enrollees move outside the 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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