Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work®

Horizon Advantage Direct Access
100/80/60
Benefit Highlight

Office Visit Copayment PCP / Specialist	Deductible In-Network	Deductible Out-of-Network	Maximum Out of Pocket In-Network	Maximum Out of Pocket 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 per 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.	
Physician'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/postnatal 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%.	$750 maximum per covered dependent child through end of calendar year in which child turns 1. $500 maximum per covered person over the age of 1 year 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 (CareCore) at **1-866-496-6200** and providing the necessary clinical information. Once the authorization number is received, the member may call CareCore 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 CareCore replace the need for a paper referral.*

Somerset Home for Temporarily Displaced Children - Plan 00 Effective 4/1/2012

Office Visit Copayment	Deductible In-Network	Deductible Out-of-Network	Maximum Out of Pocket In-Network	Maximum Out of Pocket 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 per calendar year. The deductible, coinsurance and copayments apply to the Maximum Out of Pocket.

Benefit	In-Network	Out-of-Network
Inpatient Care		
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.
Pre-admission Testing	80% after deductible.	60% after deductible.
Inpatient Physician Services	80% after deductible.	60% after deductible.
Emergency Care		
Emergency Room Copayment waived if admitted within 24 hours	80% after $100 facility copayment. No deductible applies. Payment at the in-network level across-the-board applies only to true Medical Emergencies and Accidental Injuries.	
Ambulance	80% after deductible.	60% after deductible.
	Pre-approval required for non-emergency transportation.	
Outpatient Care		
Outpatient Hospital Services	80% after deductible.	60% after deductible.
Outpatient Physician Services	80% after deductible.	60% after deductible.
Ambulatory Surgical Center (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.
Mental Health Services		
Inpatient	80% after deductible.	60% after deductible.
Outpatient Department	80% after deductible.	60% after deductible.
Office Setting	100% after copayment.	60% after deductible.
Substance Abuse Services		
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 Services		
Inpatient	80% after deductible.	60% after deductible.
Outpatient Department	80% after deductible.	60% after deductible.
Office Setting	100% after copayment.	60% after deductible.

Inpatient and Outpatient Mental Health/Substance Abuse/Alcoholism Services must be coordinated through Magellan Behavioral Health at **1-800-626-2212**.

Somerset Home for Temporarily Displaced Children - Plan 00 Effective 4/1/2012

Office Visit Copayment	Deductible In-Network	Deductible Out-of-Network	Maximum Out of Pocket In-Network	Maximum Out of Pocket 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 per calendar year. The deductible, coinsurance and copayments apply to the Maximum Out of Pocket.

Benefit	In-Network	Out-of-Network
Other Services		
Bariatric Surgery	80% after deductible. (Requires pre-approval.)	60% after deductible. (Requires pre-approval.)
Diabetic Education	80% after deductible.	60% after deductible.
Diabetic Supplies	80% after deductible.	60% after deductible.
Durable Medical Equipment	50% coinsurance.	50% after deductible.
Orthotics and Prosthetics (per New Jersey 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 Certain fertility services are excluded.	Office – 100% after copayment. Other – 80% after deductible. (Requires pre-approval.)	Office – 60% after deductible. Other – 60% after deductible. (Requires pre-approval.)
Speech and Cognitive Therapy 30 visit limit combined per year	Office – 100% after copayment. Other – 80% after deductible.	Office – 60% after deductible. Other – 60% after deductible.
Physical and Occupational Therapy 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 120 days per calendar year	80% after deductible. Must begin within 14 days of preceding hospital stay. (Requires pre-approval.)	60% after deductible. Must begin within 14 days of preceding hospital stay. (Requires pre-approval.)
Therapeutic Manipulation 30 visit maximum per calender 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%.	$750 maximum per covered dependent child through end of calendar year in which child turns 1. $500 maximum per covered person over the age of 1 year per calendar year. Not subject to deductible or coinsurance.
Vision Hardware	Not covered.	Not covered.
Prescription Drugs Prescription Card: $15/$40/$75 Refer to Prescription Plan Option #00	COPAYMENT: RETAIL (30-days) / MAIL ORDER (90 days) Generic: $15 / $30 Brand-Preferred: $40 / $100 Brand-Non-Preferred: $75 / $200	

Somerset Home for Temporarily Displaced Children - Plan 00 Effective 4/1/2012

Office Visit Copayment	Deductible In-Network	Deductible Out-of-Network	Maximum Out of Pocket In-Network	Maximum Out of Pocket 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 per calendar year. The deductible, coinsurance and copayments apply to the Maximum Out of Pocket.

Benefit	In-Network	Out-of-Network
Other Services (cont'd.)		
Eligibility	Dependent children, including full-time students are covered until their 26th birthday. Handicapped dependents are covered beyond the child removal age, if the handicap occurred prior to the age of 26. Under certain conditions, coverage may be extended for qualified dependents up to age 31. Currently enrolled dependent children who would otherwise lose coverage due to those reasons on or prior to September 23, 2010 will also have coverage extended to age 26, provided that they continue to meet any other requirements for dependents' coverage and do not have any other group or individual health care coverage.	
Pre-Existing Conditions	This plan includes a 'pre-existing conditions' limitation. In general, a pre-existing condition is a medical condition diagnosed or treated during the six months prior to a covered person's enrollment date. It applies to groups of two to five eligible employees, and to late enrollees in groups of six or more. (A late enrollee is a person who failed to enroll within 30 days of becoming eligible.) If a pre-existing condition exists, no benefits will be paid for it for 180 days after the enrollment date. The 180 days may be reduced by the time the person was covered under certain other health care coverage (Creditable Coverage) that was continuously in force to a date not more than 90 days prior to the enrollment date. Some exceptions apply to this limitation, e.g., it does not apply to covered persons under age 19 or younger; pregnancy; a child's birth defect; genetic information, in the absence of a diagnosis of the condition related to that information; or an adopted child or a child placed for adoption.	
Prior Authorization	Some services/procedures require prior authorization. For a complete list, call our Customer Service department at **1-800-355-BLUE (2583)** or refer to <**www.HorizonBlue.com**>.	

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

This summary highlights the major features of the 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. Members should refer to their 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.

Additional Information *(continued)*:

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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Somerset Home for Temporarily Displaced Children - Plan 02 Effective 4/1/2012

Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work®

Horizon HMO Benefit Highlights

Plan	Office Visit Copayment	Maximum Out of Pocket
Horizon HMO	$30	$5,000

Maximum Out of Pocket is per calendar year.
The coinsurance and copayments apply to the Maximum Out of Pocket.
Prescription copayments do not apply towards the Maximum Out of Pocket.

Benefit	**In-network**
Benefit Period Maximum	Unlimited.
Lifetime Maximum	Unlimited.
Primary Care Physician Selection	Required.
Physician Office Visit	
Physician 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.
Preventive Care	100%.
Diagnostic Procedures	
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.
Inpatient Care	
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.	100% (Unlimited days.)
Pre-admission Testing	100% after office visit copayment.
Inpatient Physician Services	100% after hospital inpatient copayment.

Somerset Home for Temporarily Displaced Children - Plan 02 Effective 4/1/2012

Plan	Office Visit Copayment	Maximum Out of Pocket
Horizon HMO	$30	$5,000

Maximum Out of Pocket is per calendar year.
The coinsurance and copayments apply to the Maximum Out of Pocket.
Prescription copayments do not apply towards the Maximum Out of Pocket.

Benefit	In-network
Emergency Care	
Emergency Room copayment waived if admitted within 24 hours.	$50 copayment.
Ambulance	100%. (Requires pre-approval.)
Outpatient Care	
Outpatient Hospital Services	100% after office visit copayment.
Ambulatory Surgery Center (ASC)	100% after office visit copayment.
Outpatient/ASC Physician Services	100% after office visit copayment.
Mental Health Services	
Inpatient	100%. (Unlimited days.)
Outpatient Department	100% after office visit copayment.
Office Setting	100% after office visit copayment.
Substance Abuse Services	
Inpatient	100% (Unlimited days.)
Outpatient Department	100% after office visit copayment.
Office Setting	100% after office visit copayment.
Alcohol Abuse Services	
Inpatient	100% (Unlimited days.)
Outpatient Department	100% after office visit copayment.
Office Setting	100% after office visit copayment.
All Inpatient and Outpatient Mental Health/Substance Abuse/Alcoholism Services must be coordinated through Magellan Behavioral Health at **1-800-626-2212**.	
Other Services	
Bariatric Surgery	100% after copayment. (Requires pre-approval.)
Diabetic Education	100% after office visit copayment.
Diabetic Supplies	100%. (Requires pre-approval.)
Durable Medical Equipment (DME)	100%. (Requires pre-approval.)

Somerset Home for Temporarily Displaced Children - Plan 02 Effective 4/1/2012

Plan	Office Visit Copayment	Maximum Out of Pocket
Horizon HMO	$30	$5,000

Maximum Out of Pocket is per calendar year.
The coinsurance and copayments apply to the Maximum Out of Pocket.
Prescription copayments do not apply towards the Maximum Out of Pocket.

Benefit	**In-network**
Other Services (cont'd)	
Orthotics and Prosthetics (per New Jersey mandate)	100% after office visit copayment.
Home Health Care	100% (Unlimited days if pre-approved.)
Hospice Care	100% (Unlimited days if pre-approved.)
Infertility *Certain fertility services are excluded.*	100% after office visit copayment. (Requires pre-approval.)
Speech and Cognitive Therapy (*30 visit limit combined per year)*	100% after office visit copayment.
Physical and Occupational Therapy (*30 visit limit combined per year)*	100% after office visit copayment.
Skilled Nursing Facility/Extended Care Center	$0 copayment (120 days combined if pre-approved).
Therapeutic Manipulation (*30 visit maximum per calendar year)*	100% after office visit copayment.
Vision Exam *Routine physical eye examinations.*	100%.
Vision Hardware	Not covered.
Prescription Drugs Prescription Card - $10-$35-$70 Refer to Prescription Option Plan 02 - HMO	COPAYMENT: RETAIL / MAIL ORDER Generic: $10 / $20 Brand-Preferred: $35 / $70 Brand-Non-Preferred: $70 / $140 30-day Supply / 90-day Supply
Eligibility	Dependent children, including full-time students are covered until their 26th birthday. Handicapped dependents are covered beyond the child removal age, if the handicap occurred prior to age 26. Under certain conditions, coverage may be extended for qualified dependents up to age 31.
Pre-Existing Conditions	This plan includes a 'pre-existing conditions' limitation. In general, a pre-existing condition is a medical condition diagnosed or treated during the six months prior to a covered person's enrollment date. It applies to groups of two to five eligible employees, and to late enrollees in groups of six or more. (A late enrollee is a person who failed to enroll within 30 days of becoming eligible.) If a pre-existing condition exists, no benefits will be paid for it for 180 days after the enrollment date. The 180 days may be reduced by the time the person was covered under certain other health care coverage (Creditable Coverage) that was continuously in force to a date not more than 90 days prior to the enrollment date. Some exceptions apply to this limitation, e.g., it does not apply to covered persons under age 19 or younger; pregnancy; a child's birth defect; genetic information, in the absence of a diagnosis of the condition related to that information; or an adopted child or a child placed for adoption.

Somerset Home for Temporarily Displaced Children - Plan 02 Effective 4/1/2012

Plan	Office Visit Copayment	Maximum Out of Pocket
Horizon HMO	$30	$5,000

Maximum Out of Pocket is per calendar year.
The coinsurance and copayments apply to the Maximum Out of Pocket.
Prescription copayments do not apply towards the Maximum Out of Pocket.

Benefit	In-network
Other Services (cont'd)	
Prior Authorization	Some services/procedures require prior authorization. For a complete list, call Member Services at **1-800-355-BLUE (2583)** or visit <**www.HorizonBlue.com**>.

This summary highlights the major features of the 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. Members should refer to their 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 8/1/09)*

Somerset Home for Temporarily Displaced Children
Prescription Plan 00 - Direct Access Advantage
Effective 4/1/2012

Plan 00 - Direct Access Adv Rx Option	Retail Copayment *(30-day supply)*	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** 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.
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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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*

Somerset Home for Temporarily Displaced Children
Prescription Option Plan 02 - HMO
Effective 4/1/2012

Plan 02 - HMO Prescription Option	Retail Copayment	Mail-Order Copayment
Generic-Preferred**	$10	$20
Brand-Preferred**	$35	$70
Brand-Non-Preferred**	$70	$140

* **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)**.

** 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** 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 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):

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, 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.
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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SOMERSET HOME FOR TEMPORARILY DISPLACED CHILDREN
Horizon Blue Cross/Blue Shield
Plans-Premiums-Employee Contribution
April 2012 Renewal

	Single	Parent/Child(s)	2 Adults	Family
Plan 00 (2012) **Basic Plan** **Direct Access Advantage**	**$30 PCP/$50 Spec Co-pay per Office Visit In Network/NA Out of Network** **Deductible: $2,500 In Network/$5,000 Out of Network** **100%/80%/60% Co-insurance** **Hospital: 80% In Network/60% Out of Network after Deductible** **In network Max $4,000/$10,000 Out of Network Max** **Rx Card: $15/$40/$75 ***			
Monthly Premium	**$ 477.58**	$ 808.08	$ 998.17	$ 1,355.50
Employee Contribution	$ 55.03	$ 385.53	$ 575.62	$ 932.95
Ee Per Pay Contribution	**$ 25.40**	**$ 177.94**	**$ 265.67**	**$ 430.59**
Plan 02 (2012) **Horizon HMO** **MUST CHOOSE PCP** **REQUIRES REFERRALS** **MUST USE IN NETWORK PROVIDERS**	**$30 Co-pay per Office Visit** **No Deductible In Network** **100% Co-insurance In Network** **Hospital: 100% In Network** **Rx Card: $10/$35/$70 Rx Card ****			
Monthly Premium	$ 614.33	$ 1,047.32	$ 1,286.66	$ 1,755.49
Employee Contribution	$ 191.78	$ 624.77	$ 864.11	$ 1,332.94
Ee Per Pay Contribution	**$ 88.51**	**$ 288.36**	**$ 398.82**	**$ 615.20**

THERE IS A FINANCIAL INCENTIVE TO PURCHASE YOUR PRESCRIPTIONS BY MAIL

		Retail - 30 Days Supply	Mail Order - 90 Days Supply
*	**Generic**	**$15**	**$30**
	Prefered (Formulary)	**$40**	**$100**
	Name Brand	**$75**	**$200**

		Retail - 30 Days Supply	Mail Order - 90 Days Supply
**	**Generic**	**$10**	**$20**
	Prefered (Formulary)	**$35**	**$70**
	Name Brand	**$70**	**$140**