Horizon Blue Cross Blue Shield of New Jersey

*Making Healthcare Work®*

# *OMNIA State Defector (with BlueCard)*

| Benefit | OMNIA Tier 1 | Tier 2 |
|---|---|---|
| **Benefit Period** | Calendar Year | |
| **Deductible** | | |
| Individual | $0 | $1,500 |
| Family | $0 | $3,000 |
| | Deductible is Calendar Year | |
| **Coinsurance** | 100% | 80% |
| **Maximum Out of Pocket** | | |
| Individual | $2,500 | $4,500 |
| Family | $5,000 | $9,000 |
| Tier 1 Ded/MOOP accumulates to Tier 2 Ded/MOOP but Tier 2 Ded/MOOP does not accumulate to Tier 1 Ded/MOOP. Once Tier 2 Ded/MOOP has been met, Tier 1 will also have been met. | | |
| Consolidated Maximum Out of Pocket is Calendar Year. The deductible, coinsurance, prescription, and copayments apply to the Maximum Out of Pocket. | | |
| **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 $5 copay<br>A primary care physician is a family practitioner, internist, pediatrician, or nurse practitioner | 100% after $20 copay |
| Specialist Office Visit | 100% after $15 copay<br>A referral is not required to visit a specialist. | 100% after $30 copay |
| Maternity Visits | 100% after $15 copay<br>Copay applies to 1st visit only<br>Dependent children are eligible for maternity/obstetrical benefits. | 100% after $30 copay |
| Allergy Testing and Treatment | 100% in office setting*<br>*Copay only applies to office visit if billed.<br>100% outpatient facility | 80% after deductible outpatient facility |
| **Preventive Care** | | |
| Routine Adult Physicals, GYN Exams, PAP, Mammograms, Prostate Cancer Screening, Colorectal Screening, Immunizations | 100% | 100% |
| Well Child Exams | 100% | 100% |
| Well Child Immunizations and Lead Screening | 100% | 100% |
| **Diagnostic Procedures** | | |
| Laboratory | 100% in office or LabCorp<br>100% after $15 copayment in outpatient facility | 100% in office or LabCorp<br>80% after deductible outpatient facility |
| X-ray/Radiology Services | 100% in office<br>100% after $15 copayment in outpatient facility | 100% in office<br>80% after deductible outpatient facility |
| 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 eviCore at **1-866-496-6200** and providing the necessary clinical information. Once the authorization number is received, the member may call eviCore at **1-866-969-1234** to schedule an appointment.<br><br>*Note: Managed Care members can call **1-866-969-1234** to obtain a confirmation number for non-Advanced Imaging diagnostic procedures. Confirmation numbers from eviCore replace the need for a paper referral.* | | |
| **Hospital Care** | | |
| Inpatient Admission | $150 copay per admission (does not apply to maternity, mental health/substance abuse or hospice) | 80% after deductible |
| Pre-admission Testing | 100% | 80% after deductible |
| Surgery in Hospital | 100% | 80% after deductible |
| Inpatient Physician Services | 100% | 80% after deductible |
| Outpatient Department Services (Non-Surgical) | 100% after $15 copay | 80% after deductible |

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| **Emergency Care** | | |
| Emergency Room | 100% after $100 facility copay (copay waived if admitted) | 100% after $100 facility copay (copay waived if admitted) |
| | Payment at the in-network level across-the-board applies only to true Medical Emergencies & Accidental Injuries. | |
| Ambulance | 100% | 100% |
| **Outpatient Surgery** | | |
| Hospital Outpatient Surgery | $150 copayment | 80% after deductible |
| Surgery in an Ambulatory SurgiCenter | $150 copayment | 80% after deductible |
| **Mental Health Services** | | |
| Inpatient | 100% | 80% after deductible |
| Outpatient Department | 100% after $15 copay | 80% after deductible |
| Office setting | 100% after $15 copay | 100% after $30 copay |
| **Substance Abuse Services** | | |
| Inpatient | 100% | 80% after deductible |
| Outpatient Department | 100% after $15 copay | 80% after deductible |
| Office setting | 100% after $15 copay | 100% after $30 copay |
| **Alcohol Abuse Services** | | |
| Inpatient | 100% | 80% after deductible |
| Outpatient Department | 100% after $15 copay | 80% after deductible |
| Office setting | 100% after $15 copay | 100% after $30 copay |
| Inpatient and Outpatient Mental Health/Substance Abuse/Alcoholism Services must be coordinated through Horizon Behavioral Health at 1-800-626-2212. | | |
| **Other Services** | | |
| Bariatric Surgery | 100% | 80% after deductible |
| Diabetic Education | 100% after office copayment | 100% after office copayment |
| Diabetic Supplies | 100% | 100% |
| Durable Medical Equipment | 100% | 100% |
| Orthotics and Prosthetics | 100% after $5 copay | 100% after $20 copay |
| Home Health Care | 100% after $5 copay | 100% after $5 copay |
| Hospice Care | 100% | 100% |
| Infertility | 100% after $15 copay office visit<br>100% after $15 copay outpatient facility | 100% after $30 copay office visit<br>80% after deductible in outpatient facility |
| Physical Rehabilitation Facility Inpatient Services | $150 per admission | 80% after deductible |
| Short-term Therapies:<br>Physical, Occupational, Speech, Respiratory | 100% after $5 copay<br>100% after $5 copay in outpatient facility | 100% after $20 copay<br>80% after deductible in outpatient facility |
| | 30 visit maximum per therapy, per benefit period | |
| Private Duty Nursing | 100% | 80% after deductible |
| | Limited to 30 visits per benefit period (8-hour shifts) | |
| Skilled Nursing Facility/Extended Care Center | $150 per admission | $150 per admission |
| | Limited to 100 days per benefit period | |
| Therapeutic Manipulation (Chiropractic Care) | 100% after $15 copay | 100% after $30 copay |
| | 25 visit maximum per benefit period | |
| Adult Vision | 100% after $15 copay | 100% after $30 copay |
| Adult Vision Hardware | Not Covered | |
| Pediatric Vision and Vision Hardware | Routine Pediatric Vision Covered 1/year and Hardware Services are covered up to $125 | |
| Telemedicine Services | 100% after $5 copay | |
| **Prescription Drugs** | Covered under freestanding prescription program | |
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| **Eligibility** | Dependent children, including full-time students are covered until the end of the calendar year in which they reach the age of 26. 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. Please refer to your benefit booklet for further information as this benefit highlight is not an exhaustive list. |
| **Prior Authorization** | Some services/procedures require prior authorization. For a complete list, contact our customer service number at 1-800-355-BLUE (2583) or refer to our website at **www.HorizonBlue.com**. |

The OMNIA plans cover eligible expenses rendered by providers in Horizon's Managed Care network. When you utilize participating providers, you generally only pay your copayment and any applicable in-network coinsurance or deductible. No benefits are available out-of-network, except in emergent situations.

Please note that the benefit highlights are provided for informational purposes. Horizon BCBSNJ makes every effort to provide clear and accurate information pertaining to these benefit highlights. However, because Horizon BCBSNJ generally expects continued guidance from regulators on issues pertaining to Federal health care reform, the information that has been provided is subject to change. Horizon BCBSNJ will provide notice of such changes to members pursuant to State and Federal requirements.

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.