Horizon
Horizon Blue Cross Blue Shield of New Jersey
Making Healthcare Work.

OMNIA 7 (HSA)

Benefit	OMNIA Tier 1	Tier 2
Benefit Period	Calendar Year	
Deductible		
Individual	$1,500	$2,500
Family	$3,000	$5,000
	Deductible is Calendar Year	
Coinsurance	90%	70%
Maximum Out of Pocket		
Individual	$3,000	6,000
Family	$6,000	12,000
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	$15 copay after deductible	$30 copay after deductible
	A primary care physician is a general or family practitioner, internist or pediatrician	
Specialist Office Visit	$25 copay after deductible	$50 copay after deductible
	A referral is not required to visit a specialist.	
Maternity Visits	$25 copay after deductible	$50 copay after deductible
	Copay applies to 1st visit only	
	Dependent children are ineligible for maternity/obstetrical benefits.	
Allergy Testing and Treatment	100% after deductible in office setting* *Copay only applies to office visit if billed.	
	90% after deductible outpatient facility	70% 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%after deductible in office or Labcorp	100%after deductible in office or Labcorp
	90% after deductible Outpatient facility	70% after deductible outpatient facility
X-ray/Radiology Services	100%after deductible in office	100%after deductible in office
	90% after deductible Outpatient facility	70% 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 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.*		
Hospital Care		
Inpatient Admission (including maternity)	90% after deductble	70% after deductible
Room and Board	90% after deductble	70% after deductible
Pre-admission Testing	90% after deductble	70% after deductible
Surgery in Hospital	90% after deductble	70% after deductible
Inpatient Physician Services	90% after deductble	70% after deductible
Outpatient Department Services	90% after deductble	70% after deductible

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Emergency Care		
	\$100 facility copay then deductible then 90%	\$100 facility copay then deductible then 70%
Emergency Room	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	90% after deductble	70% after deductible
Surgery in an Ambulatory SurgiCenter	90% after deductble	70% after deductible
Mental Health Services		
Inpatient	90% after deductble	70% after deductible
Outpatient department	90% after deductble	70% after deductible
Office setting	\$25 copay after deductible	\$50 copay after deductible
Substance Abuse Services		
Inpatient	90% after deductble	70% after deductible
Outpatient department	90% after deductble	70% after deductible
Office setting	\$25 copay after deductible	\$50 copay after deductible
Alcohol Abuse Services		
Inpatient	90% after deductble	70% after deductible
Outpatient department	90% after deductble	70% after deductible
Office setting	\$25 copay after deductible	\$50 copay after deductible
Inpatient and Outpatient Mental Health/Substance Abuse/Alcoholism Services must be coordinated through Value Options at 1-800-626-2212.		
Other Services		
Bariatric Surgery	90% after deductble	70% after deductible
Diabetic Education	Office copayment after deductible	Office copayment after deductible
Diabetic Supplies	90% after deductble	90% after deductble
Durable Medical Equipment	90% after deductble	90% after deductble
Orthotics and Prosthetics (Per NJ mandate)	\$15 copay after deductible	\$30 copay after deductible
Home Health Care	\$15 copay after deductible	\$15 copay after deductible
Hospice Care	90% after deductble	90% after deductble
Infertility (including in-vitro fertilization)	90% after deductble	70% after deductible
	Limited to 4 egg retrievals per lifetime	
Physical Rehabilitation Facility Inpatient Services	90% after deductble	70% after deductible
Short-term Therapies: Physical, Occupational, Speech, Respiratory	\$15 copay after deductible	\$30 copay after deductible
	90% after deductible in outpatient facility	70% after deductible in outpatient facility
	30 visit maximum per therapy, per benefit period	
Private Duty Nursing	90% after deductble	70% after deductible
	Limited to 30 visits per benefit period (8-hour shifts)	
Skilled Nursing Facility/Extended Care Center	90% after deductble	90% after deductble
	Limited to 100 days per benefit period	
Therapeutic Manipulation (Chiropractic Care)	\$25 copay after deductible	\$30 copay after deductible
	25 visit maximum per benefit period	
Adult Vision	Not Covered	Not Covered
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	\$5 copay after deductible	
Prescription Drugs	70% after Tier 1 deductible	

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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.
Pre-Existing Conditions	Not Applicable
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 cvoer 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. Please refer to your benefit booklet for further information as this benefit highlight is not an exhaustive list.

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.

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Three Penn Plaza East, Newark, New Jersey 07105