

## OMNIA 3 (with BlueCard) Middlesex County

Benefit	OMNIA Tier 1	Tier 2
<b>Benefit Period</b>	Calendar Year	
<b>Deductible</b>		
Individual	\$0	\$1,500
Family	\$0	\$3,000
	Deductible is Calendar Year	
<b>Coinsurance</b>	100%	80%
<b>Maximum Out of Pocket</b>		
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.		
<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 \$5 copay A primary care physician is a family practitioner, internist, pediatrician, or nurse practitioner	100% after \$20 copay
Specialist Office Visit	100% after \$15 copay A referral is not required to visit a specialist.	100% after \$30 copay
Maternity Visits	100% after \$15 copay Dependent children are eligible for maternity/obstetrical benefits.	100% after \$30 copay Copoly applies to 1st visit only
Allergy Testing and Treatment	100% outpatient facility	80% after deductible outpatient facility 100% in office setting* *Copoly only applies to office visit if billed.
<b>Preventive Care</b>		
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%
<b>Diagnostic Procedures</b>		
Laboratory	100% in office or LabCorp/Quest 100% in outpatient facility	100% in office or LabCorp/Quest 80% after deductible outpatient facility
X-ray/Radiology Services	100% in office 100% in outpatient facility	100% in office 80% after deductible outpatient facility
Complex Imaging (CT/CTA Scans, Pet Scans, MRIs/MRAs, Nuclear Medicine studies (including Nuclear Cardiology)) require prior authorization and may pay at a different benefit level than X-ray/Radiology services. The ordering physician should request the prior authorization by calling eviCore at <b>1-866-496-6200</b> and providing the necessary clinical information. Once the authorization number is received, the member may call eviCore at <b>1-866-969-1234</b> to schedule an appointment.		
<i>Note: Managed Care members can call <b>1-866-969-1234</b> to obtain a confirmation number for non-Advanced Imaging diagnostic procedures. Confirmation numbers from eviCore replace the need for a paper referral.</i>		
<b>Hospital Care</b>		
Inpatient Admission (including maternity)	\$250 per day up to 5 day maximum	80% after deductible
Room and Board	100%	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	100% after \$100 facility copay
Ambulance	100%	100%
Payment at the in-network level across-the-board applies only to true Medical Emergencies & Accidental Injuries.		
Outpatient Surgery		
Hospital Outpatient Surgery	\$150 copayment	80% after deductible
Surgery in an Ambulatory SurgiCenter	\$100 copayment	80% after deductible
Mental Health Services		
Inpatient	\$250 per day up to 5 day maximum	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	\$250 per day up to 5 day maximum	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	\$250 per day up to 5 day maximum	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%	80% after deductible
Durable Medical Equipment	100%	80% after deductible
Orthotics and Prosthetics	100% after \$5 copay	100% after \$20 copay
Home Health Care	100% after \$5 copay	100% after \$20 copay
Hospice Care	\$250 per day up to 5 day maximum	80% after deductible
Infertility	100% after \$15 copay office visit 100% after \$15 copay outpatient facility	100% after \$30 copay office visit 80% after deductible in outpatient facility
Physical Rehabilitation Facility Inpatient Services	\$250 per day up to 5 day maximum	80% after deductible
Short-term Therapies: Physical, Occupational, Speech, Respiratory	100% after \$5 copay 100% after \$15 copay in outpatient facility 30 visit maximum per therapy, per benefit period	100% after \$20 copay 80% after deductible in outpatient facility
Private Duty Nursing	100%	80% after deductible
Skilled Nursing Facility/Extended Care Center	\$250 per day up to 5 day maximum Limited to 30 visits per benefit period (8-hour shifts)	80% after deductible
Therapeutic Manipulation (Chiropractic Care)	100% after \$15 copay 25 visit maximum per benefit period	100% after \$30 copay
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 \$150	
Telemedicine Services	Not Covered	
Prescription Drugs		
Covered under freestanding prescription program		



Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work<sup>®</sup>

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<b>Eligibility</b>	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.
<b>Pre-Existing Conditions</b>	Not Applicable
<b>Prior Authorization</b>	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 <a href="http://www.HorizonBlue.com">www.HorizonBlue.com</a> .

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.

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