Horizon

OMNIA
Georgian Court University
Plan Option #2

Benefit	OMNIA Tier 1	Tier 2
Benefit Period	Calendar Year	
Deductible		
Individual	$1,000	$2,500
Family	$2,000	$5,000
	Deductible is Calendar Year	
Coinsurance	90%	70%
Maximum Out of Pocket		
Individual	$3,500	$6,500
Family	$7,000	$13,000
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 $20 copay A primary care physician is a family practitioner, internist, pediatrician, or nurse practitioner	100% after $40 copay
Specialist Office Visit	100% after $40 copay A referral is not required to visit a specialist.	100% after $50 copay
Maternity Visits	100% after $40 copay Copay applies to 1st visit only Dependent children are ineligible for maternity/obstetrical benefits.	100% after $50 copay
Allergy Testing and Treatment	100% 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% in office or LabCorp/Quest 90% after deductible in outpatient facility	100% in office or LabCorp/Quest 70% after deductible outpatient facility
X-ray/Radiology Services	100% in office 90% after deductible in outpatient facility	100% in office 70% 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 **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. *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 (including maternity)	90% after deductible	70% after deductible
Room and Board	90% after deductible	70% after deductible
Pre-admission Testing	90% after deductible	70% after deductible
Surgery in Hospital	90% after deductible	70% after deductible
Inpatient Physician Services	90% after deductible	70% after deductible
Outpatient Department Services (Non-Surgical)	90% after deductible	70% after deductible
Emergency Care		
Emergency Room	$100 facility copay then deductible then 90% Payment at the in-network level across-the-board applies only to true Medical Emergencies & Accidental Injuries.	$100 facility copay then deductible then 90%
Ambulance	100% after Tier 1 deductible	100% after Tier 1 deductible
Outpatient Surgery		
Hospital Outpatient Surgery	90% after deductible	70% after deductible

Surgery in an Ambulatory SurgiCenter	90% after deductible	70% after deductible
Mental Health Services		
Inpatient	90% after deductible	70% after deductible
Outpatient Department	90% after deductible	70% after deductible
Office setting	100% after $40 copay	100% after $50 copay
Substance Abuse Services		
Inpatient	90% after deductible	70% after deductible
Outpatient Department	90% after deductible	70% after deductible
Office setting	100% after $40 copay	100% after $50 copay
Alcohol Abuse Services		
Inpatient	90% after deductible	70% after deductible
Outpatient Department	90% after deductible	70% after deductible
Office setting	100% after $40 copay	100% after $50 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	90% after deductible	70% after deductible
Diabetic Education	100% after office copayment	100% after office copayment
Diabetic Supplies	90% after deductible	70% after deductible
Durable Medical Equipment	90% after deductible	70% after deductible
Orthotics and Prosthetics	100% after $20 copay	100% after $40 copay
Home Health Care	100% after $20 copay	100% after $40 copay
Hospice Care	90% after deductible	70% after deductible
Infertility	90% after deductible	70% after deductible
Physical Rehabilitation Facility Inpatient Services	90% after deductible	70% after deductible
Short-term Therapies: Physical, Occupational, Speech, Respiratory	100% after $20 copay 90% after deductible in outpatient facility 30 visit maximum per therapy, per benefit period	100% after $30 copay 70% after deductible in outpatient facility
Private Duty Nursing	90% after deductible in outpatient facility Limited to 30 visits per benefit period (8-hour shifts)	70% after deductible
Skilled Nursing Facility/Extended Care Center	90% after deductible Limited to 100 days per benefit period	70% after deductible
Therapeutic Manipulation (Chiropractic Care)	100% after $30 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	100% after $10 copay	
Prescription Drugs	Covered under freestanding prescription program	
Eligibility	Dependent children, including full-time students are covered until the end of the month 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.	
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 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. 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.