

# OMNIA 3 (with BlueCard)

## Centenary University

7/1/2020-6/30/2021

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 ineligible for maternity/obstetrical benefits.	100% after \$30 copay
Allergy Testing and Treatment	100% outpatient facility 100% in office setting* *Copay only applies to office visit if billed.	80% after deductible outpatient facility
<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 Payment at the in-network level across-the-board applies only to true Medical Emergencies & Accidental Injuries.	100% after \$100 facility copay
Ambulance	100%	100%
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) Limited to 100 days per benefit period	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	100% after \$5 copay	
Prescription Drugs		
Covered under freestanding prescription program		

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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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The Prescription Drug Program covers FDA approved legend drugs. A prescription order from a physician is required for drugs to be eligible. Prescriptions may be refilled within one year of the original prescription date, when authorized by the physician and permitted by law. Any limitations that apply to an original prescription also apply to the refills.

The Horizon Prescription Formulary is a list of prescription medications developed by an independent Pharmacy and Therapeutics (P&T) Committee comprised of practicing physicians and pharmacists in New Jersey. The Horizon P&T Committee determines which drugs will be placed into preferred and non-preferred status within our open formulary. The priority consideration is clinical efficacy and safety, followed by other considerations such as second line therapies, and availability of commonly used and safe generics. At least two drugs from each therapeutic class are placed in the preferred status on the formulary. Once a quality review has determined that two or more drugs are equal to other therapeutic alternatives, the P&T Committee may place the most cost effective drug(s) into preferred status.

Type of Program	Preferred Generic Drugs	Preferred Brand Name Drugs	Non-Preferred Drugs
<b>Three Tier Copayment Plan:</b>			
<b>Retail:</b> Up to a 90 day supply <small>(1 retail copay applies per 30-day supply)</small>	\$15	\$50	\$75
<b>Mail Order:</b> Up to 90 day supply <small>(1 mail order copay applies for the 90-day supply)</small>	\$35	\$125	\$200
<b>Front End Deductible (applies to retail and mail):</b> Amount excluding copayments/co-insurance, which must be incurred per member in a benefit period before benefits are paid.		Not Applicable	
<b>Benefit Period Maximum:</b>		Unlimited	

**Plan includes:**

- Contraceptive (self-administered or injectible) drugs & devices obtained at a pharmacy
- Diabetic Supplies
- Fertility Drugs
- DAW1 Program (Dispense as Written) - If **prescriber** requests brand drug when generic equivalent is available, prior authorization will be required and the non-preferred copay is charged.
- DAW2 Program - If **member** requests brand drug when generic equivalent is available, the generic copay PLUS the cost difference between the brand and generic will be assessed.
- Prior Authorization - Certain medications that have medical utility for only a select group of patients require PA before coverage is approved. Specific guidelines, developed and approved by physicians and pharmacists, have to be met for these drugs to be approved and covered under your prescription drug benefits. See Horizon BCBSNJ's website for the PA drug list.

**Specialty Pharmacy Program:**

Certain specialty pharmaceuticals must be obtained from one of the contracted pharmacies. Specialty pharmaceuticals are typically used to treat conditions such as: Adenosine Deaminase Deficiency, Allergic Asthma, Alpha-1 Proteinase Inhibitor Deficiency, Anemia, Crohn's Disease, Cytomegalovirus, Fabry's Disease, Gaucher Disease, Hypercalcemia of Malignancy, Neutropenia, Prostate Cancer, Psoriasis, Pulmonary Hypertension, Respiratory Syncytial Virus, and Rheumatoid Arthritis.

- Personal attention from a pharmacist-led team that provides condition-specific education, medication administration instruction and expert advice to help manage therapy.
- Claims assistance to help determine individual coverage and file the necessary paperwork.
- Easy access to pharmacists and other health experts 24 hours a day, seven days a week.
- Single, reliable source for specialty medication needs.
- Easy ordering with a dedicated toll-free number.
- Confidential and convenient delivery to the location of choice (i.e., home, physician's office.)
- Helpful follow-up care calls to remind when it's time to refill a prescription, check on therapy progress and answer any questions.
- NOTE: Specialty pharmacies are considered "retail" pharmacies and are always subject to the retail copayment levels, even if the specialty pharmaceutical is obtained through the mail.

**Exclusions:**

- Anti-Obesity Drugs
- Over The Counter Vitamins & Minerals
- Growth Hormones (unless prior authorized)
- Drugs for Cosmetic Purposes
- Immunization Agents and Allergy Serum
- Lifestyle Drugs

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For more information about your prescription drug plan, please refer to our website at [www.HorizonBlue.com](http://www.HorizonBlue.com) under Member Information. Should you have any additional questions, please feel free to contact Member Services at the phone number listed on your identification card.

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