



# OMNIA 7 HSA (with BlueCard)

## Air Group, LLC

6/1/2024 to 5/31/2025

Benefit	OMNIA Tier 1	Tier 2
<b>Benefit Period</b>	Contract Year	
<b>Deductible</b>		
Individual	\$1,600	\$2,500
Family	\$3,200	\$5,000
	Deductible is Contract Year	
<b>Coinsurance</b>	90%	70%
<b>Maximum Out of Pocket</b>		
Individual	\$3,200	\$6,000
Family	\$6,400	\$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.		
<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	90% after deductible A primary care physician is a family practitioner, internist, pediatrician, or nurse practitioner	70% after deductible
Specialist Office Visit	90% after deductible A referral is not required to visit a specialist.	70% after deductible
Maternity Visits	90% after deductible	70% after deductible
Allergy Testing and Treatment	Dependent children are ineligible for maternity/obstetrical benefits. 100% after deductible in office setting* *Copay only applies to office visit if billed.	
	90% after deductible outpatient facility	70% 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% after deductible in office or LabCorp/Quest 100% after deductible outpatient facility	100% after deductible in office or LabCorp/Quest 70% after deductible outpatient facility
X-ray/Radiology Services	100% after deductible in office 100% after deductible outpatient facility	100% after deductible 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 <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)	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



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<b>Emergency Care</b>		
	90% after deductible	90% after deductible
Emergency Room	Payment at the in-network level across-the-board applies only to true Medical Emergencies & Accidental Injuries.	
Ambulance	100% after Tier 1 deductible	100% after Tier 1 deductible
<b>Outpatient Surgery</b>		
Hospital Outpatient Surgery	90% after deductible	70% after deductible
Surgery in an Ambulatory SurgiCenter	90% after deductible	70% after deductible
<b>Mental Health Services</b>		
Inpatient	90% after deductible	70% after deductible
Outpatient Department	90% after deductible	70% after deductible
Office setting	90% after deductible	70% after deductible
<b>Substance Use Disorder Services</b>		
Inpatient	90% after deductible	70% after deductible
Outpatient Department	90% after deductible	70% after deductible
Office setting	90% after deductible	70% after deductible
<b>Alcoholism Treatment</b>		
Inpatient	90% after deductible	70% after deductible
Outpatient Department	90% after deductible	70% after deductible
Office setting	90% after deductible	70% after deductible
Inpatient and Outpatient Mental Health/Substance Use Disorder Services/Alcoholism Treatment must be coordinated through Horizon Behavioral Health at 1-800-626-2212.		
<b>Other Services</b>		
Bariatric Surgery	90% after deductible	70% after deductible
Diabetic Education	90% after deductible	70% after deductible
Diabetic Supplies	90% after deductible	70% after deductible
Durable Medical Equipment	90% after deductible	70% after deductible
Orthotics and Prosthetics	90% after deductible	70% after deductible
Home Health Care	90% after deductible	70% after deductible
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	90% after deductible 90% after deductible in outpatient facility 30 visit maximum per therapy, per benefit period	70% after deductible 70% after deductible in outpatient facility
Private Duty Nursing	90% after deductible 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)	90% after deductible 25 visit maximum per benefit period	70% after deductible
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	90% after deductible	
<b>Prescription Drugs</b>		
Covered under freestanding plan		



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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. 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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