Plans Benefit Details

Here's what to keep in mind when comparing plans.

Gold, Silver and Bronze plan levels correspond to how much you pay versus how much Horizon BCBSNJ pays when you get care.

Members will have lower out-of-pocket costs when using OMNIA Tier 1. Out-of-pocket costs may be higher with Advantage EPO Plans when compared with OMNIA Health Plans in similar "metal" tiers.

Whether you choose an OMNIA or Advantage Health Plan, you do not need to choose a Primary Care Physician or get a referral to see specialists.

The Essentials Plan is a low-cost, high-deductible option designed for healthy individuals under age 30.

All plans include 10 categories of essential health benefits (see page 7 for list).

Terms to know

Premium: What you pay each month for health insurance coverage.

Copayment: The fixed amount you must pay after you've paid the deductible for each medical visit to a participating doctor or other health care provider, usually at the time of service.

Coinsurance: The percentage of a covered charge that you must pay.

Deductible: The amount you must pay each year for covered charges before benefits are paid by your plan.

Out-of-Pocket Maximum (MOOP): The most you must pay for covered health care services during a plan year.

Understanding family costs

True Family Aggregate Deductible: It is possible that one or more members can exceed their individual deductible because the family deductible must be met first. The family deductible can be met by one member on the policy or a combination of members. The OMNIA Silver HSA and Bronze HSA plans have this type of deductible.

Aggregate Deductible: Each family member only needs to meet the individual deductible, and the family deductible amount can be met by one member on the policy or a combination of family members. OMNIA Gold and Silver plans have this type of deductible.

Family Out-of-Pocket Maximum (MOOP) Amounts: Per federal regulation, no one person can exceed the individual MOOP amount. This means that once one family member meets the individual MOOP amount, that family member will pay no more covered charges.

For a family of two, each individual will have to meet the individual MOOP amounts on his/her own. For a family of more than two, any combination of family members can help meet the family MOOP, with no individual exceeding the individual MOOP amount. If the family MOOP is met before any family member reaches his/her individual MOOP, no one will be billed for any covered charges.

Horizon OMNIA℠ Health Plans

BENEFITS		OMNIA Gold		OMNIA Silver HSA		OMNIA Silver		OMNIA Bronze HSA	
		OMNIA Tier 1	Tier 2	OMNIA Tier 1	Tier 2	OMNIA Tier 1	Tier 2	OMNIA Tier 1	Tier 2
GENERAL PROVISIONS	Primary Care Physician (PCP) Required?	No	No	No	No	No	No	No	No
	Out-of-Network/Area Coverage?	No	No	No	No	No	No	No	No
	Individual Deductible*	$1,000	$2,500	$1,800*	$2,500*	$1,500	$2,500	$3,000*	$3,000*
	Family Deductible	$2,000	$5,000	$3,600	$5,000	$3,000	$5,000	$6,000	$6,000
	Individual Drug Deductible	NA	NA	NA	NA	$200	$200	NA	NA
	Family Drug Deductible	NA	NA	NA	NA	$400	$400	NA	NA
	Individual Maximum Out-of-Pocket	$4,500	$6,350	$6,000	$6,550	$7,350	$7,350	$6,550	$6,550
	Family Maximum Out-of-Pocket	$9,000	$12,700	$12,000	$13,100	$14,700	$14,700	$13,100	$13,100
HEALTH CARE SERVICES	PCP Office Visits & Consultations	$10 copayment	Deductible then $30 copayment	Deductible then $15 copayment	Deductible then $30 copayment	$30 copayment	Deductible then 50% coinsurance	Deductible then $30 copayment	Deductible then 50% coinsurance
	Specialist Visits & Consultations	$25 copayment	Deductible then $50 copayment	Deductible then $30 copayment	Deductible then $50 copayment	$50 copayment	Deductible then 50% coinsurance	Deductible then $50 copayment	Deductible then 50% coinsurance
DIAGNOSTIC TESTS AND IMAGING	Lab/Radiology Free Standing	No Charge	No Charge	Deductible	Deductible	No Charge	No Charge	Deductible then No Charge	Deductible then No Charge
	Lab Office Visit	No Charge	No Charge	Deductible	Deductible	No Charge	No Charge	Deductible then No Charge	Deductible then No Charge
	Radiology Office Visit	$10 PCP copayment or $25 Specialist copayment	Deductible then $30 PCP copayment or Deductible then $50 Specialist copayment	Deductible then $15 PCP copayment or Deductible then $30 Specialist copayment	Deductible then $30 PCP copayment or Deductible then $50 Specialist copayment	$30 PCP copayment or $50 Specialist copayment	Deductible then 50% coinsurance	Deductible then $30 PCP copayment or Deductible then $50 Specialist copayment	Deductible then 50% coinsurance
	Lab/Radiology Outpatient	Deductible then $20 copayment	Deductible then 30% coinsurance	Deductible then No Charge	Deductible then 50% coinsurance	Deductible then $50 copayment	Deductible then 50% coinsurance	Deductible then No Charge	Deductible then 50% coinsurance
PHARMACY SERVICES	Generic Drugs	$10 copayment (retail) $20 copayment (mail order)	$10 copayment (retail) $20 copayment (mail order)	Deductible then 50% coinsurance	Deductible then 50% coinsurance	$15 copayment (retail) $30 copayment (mail order)	$15 copayment (retail) $30 copayment (mail order)	Deductible then 50% coinsurance	Deductible then 50% coinsurance
	Preferred Brand Drugs	40% coinsurance	40% coinsurance	Deductible then 50% coinsurance	Deductible then 50% coinsurance	Deductible then 50% coinsurance	Deductible then 50% coinsurance	Deductible then 50% coinsurance	Deductible then 50% coinsurance
	Non-Preferred Brand Drugs & Specialty Drugs	50% coinsurance	50% coinsurance	Deductible then 50% coinsurance	Deductible then 50% coinsurance	Deductible then 50% coinsurance	Deductible then 50% coinsurance	Deductible then 50% coinsurance	Deductible then 50% coinsurance
OUTPATIENT SURGERY SERVICES	Both Hospital & Physician/Surgeon	Deductible then $250 copayment	Deductible then 30% coinsurance	Deductible then 30% coinsurance	Deductible then 50% coinsurance	Deductible then $250 copayment	Deductible then 50% coinsurance	Deductible then 50% coinsurance	Deductible then 50% coinsurance
	Both Ambulatory Surgical Hospital & Physician/Surgeon	Deductible then $250 copayment	NA	Deductible then 30% coinsurance	NA	Deductible then $250 copayment	NA	Deductible then 50% coinsurance	NA
EMERGENCY/URGENT MEDICAL SERVICES	ER Hospital	$100 copayment & Deductible	$100 copayment & Deductible	$100 copayment & Deductible, then 30% coinsurance	$100 copayment & Deductible, then 30% coinsurance	$100 copayment & Deductible	$100 copayment & Deductible	$100 copayment & Deductible, then 50% coinsurance	$100 copayment & Deductible, then 50% coinsurance
	ER Professional	Deductible	Deductible	Deductible then 30% coinsurance	Deductible then 30% coinsurance	Deductible	Deductible	Deductible then 50% coinsurance	Deductible then 50% coinsurance
	Medical Transportation	Deductible then No Charge	NA	Deductible then 30% coinsurance	NA	Deductible then No Charge	NA	Deductible then No Charge	NA
	Urgent Care Center	$25 copayment	Deductible then $50 copayment	Deductible then $30 copayment	Deductible then $50 copayment	$50 copayment	Deductible then 50% coinsurance	Deductible then $50 copayment	Deductible then 50% coinsurance
HOSPITAL SERVICES	Outpatient Hospital & Physician	Deductible then $20 copayment	Deductible then 30% coinsurance	Deductible then 30% coinsurance	Deductible then 50% coinsurance	Deductible then $50 copayment	Deductible then 50% coinsurance	Deductible then 50% coinsurance	Deductible then 50% coinsurance
	Inpatient Hospital	Deductible then $500 per day copayment	Deductible then 30% coinsurance	Deductible then 30% coinsurance	Deductible then 50% coinsurance	Deductible then $500 per day copayment	Deductible then 50% coinsurance	Deductible then $500 per day copayment	Deductible then 50% coinsurance
	Physician/Surgeon	Deductible	Deductible then 30% coinsurance	Deductible then 30% coinsurance	Deductible then 50% coinsurance	Deductible	Deductible then 50% coinsurance	Deductible then No Charge	Deductible then 50% coinsurance
BEHAVIORAL HEALTH/SUBSTANCE ABUSE	PCP	$10 copayment	Deductible then $30 copayment	Deductible then $15 copayment	Deductible then $30 copayment	$30 copayment	Deductible then 50% coinsurance	Deductible then $30 copayment	Deductible then 50% coinsurance
	Specialist Office Visit	$25 copayment	Deductible then $50 copayment	Deductible then $30 copayment	Deductible then $50 copayment	$50 copayment	Deductible then 50% coinsurance	Deductible then $50 copayment	Deductible then 50% coinsurance
	Outpatient	Deductible then $20 copayment	Deductible then 30% coinsurance	Deductible then 30% coinsurance	Deductible then 50% coinsurance	Deductible then $50 copayment	Deductible then 50% coinsurance	Deductible then 50% coinsurance	Deductible then 50% coinsurance
	Inpatient	Deductible then $500 per day copayment	Deductible then 30% coinsurance	Deductible then 30% coinsurance	Deductible then 50% coinsurance	Deductible then $500 per day copayment	Deductible then 50% coinsurance	Deductible then $500 per day copayment	Deductible then 50% coinsurance
MATERNITY SERVICES	Delivery & All Inpatient Services	Deductible then $500 per day copayment	Deductible then 30% coinsurance	Deductible then 30% coinsurance	Deductible then 50% coinsurance	Deductible then $500 per day copayment	Deductible then 50% coinsurance	Deductible then $500 per day copayment	Deductible then 50% coinsurance
OTHER SERVICES	In-Home Health Care	$10 copayment	NA	Deductible then $15 copayment	NA	$30 copayment	NA	Deductible then $30 copayment	NA
	Rehabilitation, Hospice & Skilled Nursing Care** – Inpatient	Deductible then $500 per day copayment	Deductible then 30% coinsurance	Deductible then 30% coinsurance	Deductible then 50% coinsurance	Deductible then $500 per day copayment	Deductible then 50% coinsurance	Deductible then $500 copayment	Deductible then 50% coinsurance
	Durable Medical Equipment	No Charge	NA	Deductible	NA	No Charge	NA	Deductible then No Charge	NA
	Chiropractic Care – 30 visits per year maximum	$10 copayment	Deductible then $30 copayment	Deductible then $15 copayment	Deductible then $30 copayment	$30 copayment	Deductible then 50% coinsurance	Deductible then $30 copayment	Deductible then 50% coinsurance

*Members receiving cost-sharing reduction subsidies may not be eligible for an HSA under this plan as some variations of this plan do not meet the IRS requirements of a High-Deductible Health Plan.

** For 2018 all Hospice & Skilled Nursing providers are Tier 1.

2018 Premium Rates

Horizon OMNIA Health Plans

Age	Gold	Silver	Silver HSA	Bronze HSA
0-14	$413.27	$284.55	$265.24	$228.17
15	$450.01	$309.84	$288.82	$248.45
16	$464.05	$319.51	$297.83	$256.21
17	$478.10	$329.18	$306.85	$263.96
18	$493.23	$339.60	$316.56	$272.32
19	$508.35	$350.01	$326.26	$280.67
20	$524.02	$360.80	$336.32	$289.32
21–24	$540.23	$371.96	$346.72	$298.26
25	$542.39	$373.45	$348.11	$299.46
26	$553.19	$380.89	$355.04	$305.42
27	$566.16	$389.81	$363.36	$312.58
28	$587.23	$404.32	$376.89	$324.21
29	$604.51	$416.22	$387.98	$333.76
30	$613.16	$422.17	$393.53	$338.53
31	$626.12	$431.10	$401.85	$345.69
32	$639.09	$440.03	$410.17	$352.85
33	$647.19	$445.61	$415.37	$357.32
34	$655.84	$451.56	$420.92	$362.09
35	$660.16	$454.53	$423.69	$364.48
36	$664.48	$457.51	$426.47	$366.86
37	$668.80	$460.48	$429.24	$369.25
38	$673.12	$463.46	$432.01	$371.64
39	$681.77	$469.41	$437.56	$376.41
40	$690.41	$475.36	$443.11	$381.18
41	$703.38	$484.29	$451.43	$388.34
42	$715.80	$492.84	$459.41	$395.20
43	$733.09	$504.75	$470.50	$404.74
44	$754.70	$519.63	$484.37	$416.67
45	$780.09	$537.11	$500.67	$430.69
46	$810.34	$557.94	$520.08	$447.40
47	$844.37	$581.37	$541.93	$466.19
48	$883.27	$608.15	$566.89	$487.66
49	$921.63	$634.56	$591.51	$508.84
50	$964.85	$664.32	$619.24	$532.70
51	$1,007.52	$693.70	$646.63	$556.26
52	$1,054.52	$726.06	$676.80	$582.21
53	$1,102.06	$758.79	$707.31	$608.46
54	$1,153.38	$794.13	$740.25	$636.79
55	$1,204.71	$829.47	$773.19	$665.13
56	$1,260.35	$867.78	$808.90	$695.85
57	$1,316.53	$906.46	$844.96	$726.87
58	$1,376.50	$947.75	$883.45	$759.98
59	$1,406.21	$968.21	$902.52	$776.38
60	$1,466.18	$1,009.49	$941.00	$809.49
61	$1,518.04	$1,045.20	$974.29	$838.12
62	$1,552.07	$1,068.64	$996.13	$856.91
63	$1,594.75	$1,098.02	$1,023.52	$880.48
64 and over	$1,620.68	$1,115.87	$1,040.16	$894.78

Horizon Advantage EPO Health Plans

Age	Essentials	Silver	Bronze
0-14	$201.56	$354.33	$287.84
15	$219.48	$385.83	$313.43
16	$226.33	$397.87	$323.21
17	$233.18	$409.92	$332.99
18	$240.56	$422.89	$343.53
19	$247.94	$435.86	$354.06
20	$255.58	$449.29	$364.97
21–24	$263.48	$463.18	$376.26
25	$264.53	$465.04	$377.77
26	$269.80	$474.30	$385.29
27	$276.13	$485.42	$394.32
28	$286.40	$503.48	$409.00
29	$294.83	$518.30	$421.04
30	$299.05	$525.71	$427.06
31	$305.37	$536.83	$436.09
32	$311.70	$547.95	$445.12
33	$315.65	$554.89	$450.76
34	$319.87	$562.30	$456.78
35	$321.97	$566.01	$459.79
36	$324.08	$569.71	$462.80
37	$326.19	$573.42	$465.81
38	$328.30	$577.13	$468.82
39	$332.51	$584.54	$474.84
40	$336.73	$591.95	$480.86
41	$343.05	$603.06	$489.89
42	$349.11	$613.72	$498.55
43	$357.54	$628.54	$510.59
44	$368.08	$647.07	$525.64
45	$380.47	$668.84	$543.32
46	$395.22	$694.77	$564.39
47	$411.82	$723.95	$588.10
48	$430.79	$757.30	$615.19
49	$449.50	$790.19	$641.90
50	$470.58	$827.24	$672.01
51	$491.39	$863.84	$701.73
52	$514.31	$904.13	$734.46
53	$537.50	$944.89	$767.58
54	$562.53	$988.90	$803.32
55	$587.56	$1,032.90	$839.07
56	$614.70	$1,080.61	$877.82
57	$642.10	$1,128.78	$916.95
58	$671.35	$1,180.19	$958.72
59	$685.84	$1,205.67	$979.41
60	$715.09	$1,257.08	$1,021.18
61	$740.38	$1,301.54	$1,057.30
62	$756.98	$1,330.72	$1,081.00
63	$777.79	$1,367.32	$1,110.73
64 and over	$790.44	$1,389.54	$1,128.78