Washington Township Board of Education

Horizon Blue Cross Blue Shield of NJ

Plan Design Comparisons

Current PPO Design 1 vs. Omnia Design 3 vs. Advantage EPO Design 1

	Current Plan - Blue Card PPO Design 1		OMNIA Design 3		Advantage EPO Design 1
Benefit	**In-Network**	**Out-of-Network**	**TIER 1**	**TIER 2**	**In-Network ONLY**
Benefit Period	Calendar Year		Calendar Year		Calendar Year
Network	**Blue Card PPO Network - Nationwide**		**In NJ - OMNIA Tier 1 and Tier 2 Proviers** **Outside NJ - BlueCard PPO are TIER 2 only** **IN-NETWORK ONLY, there are no out of network benefits.**		**NJ - Horizon Managed Care Network** **Outside NJ - Blue Card PPO Network** **IN-NETWORK ONLY, there are no out of network benefits.**
Deductible					
Individual	None	$400	None	$1,500	None
Family	None	$800	None	$3,000	None
	Deductible is Calendar Year		Deductible is Calendar Year		
Coinsurance	100%	80%	100%	80%	100%
Maximum Out of Pocket					
Individual	$400	$400	$2,500	$4,500	$2,500
Family	$800	$800	$5,000	$9,000	$5,000
Benefit Period Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Primary Care Physician Selection	Not Required		Not Required		Not Required
Specialist Referral	Not Required		Not Required		Not Required
Doctor's Office Visits					
Primary Care Office Visits	100% after $15 copay	80% after deductible	100% after $5 copay	100% after $20 copay	100% after $20 copay
Specialist Office Visits	100% after $15 copay	80% after deductible	100% after $15 copay	100% after $30 copay	100% after $40 copay
Maternity Visits	100% after $15 copay Copay applies to 1st visit only	80% after deductible	100% after $15 copay Copay applies to 1st visit only	100% after $30 copay	100% after $40 copay Copay applies to 1st visit only
	Dependent Children are ineligible for Maternity/Obstetrical Benefits.		**Dependent Children are eligible for Maternity/Obstetrical Benefits**		**Dependent Children are eligible for Maternity/Obstetrical Benefits.**
Allergy Testing and Treatment	100%	80% after deductible	100% in office setting* 100% Outpatient facility	100% in office setting* 80% after ded. Outpatient facility	100%
	Note: A copay will only apply when an office visit is billed.		***Copay will only apply when an office visit is billed.**		**Note: A copay will only apply when an office visit is billed.**
Preventive Care					
Routine Adult Physicals, GYN Exams, PAP, Mammograms, Prostate Cancer Screening, Colorectal Screening, Immunizations	100%	80% (no deductible)	100%	100%	100%
Well Child Exams	100%	80% (no deductible)	100%	100%	100%
Well Child Immunizations and Lead Screening	100%	80% (no deductible)	100%	100%	100%
Diagnostic Procedures					
Laboratory	100% in Office or Labcorp 100% in Outpatient facility	80% after deductible	100% in Office or Labcorp 100% after $15 copay in Outpatient facility	100% in office or Labcorp 80% after deductible in Outpatient Facility	100% in Office or Labcorp 100% in Outpatient facility
Outpatient X-ray/Radiology Services	100% in Office 100% in Outpatient facility	80% after deductible	100% in Office 100% after $15 copay in Outpatient facility	100% in Office 80% after deductible in Outpatient Facility	100% in Office 100% in Outpatient facility
	CT/CTA Scans, Pet Scans, MRIs/MRAs, Nuclear Medicine studies(including Nuclear Cardiology) require prior authorization. The ordering physician should request the prior authorization by calling CareCore National, LLC(CCN) at 1-866-496-6200 and providing necessary clinical information. Once the authorizaton number is received, the member may call CCN at 1-866-969-1234 to schedule an appointment.				
Hospital Care					
Inpatient Admission (including maternity)	100%	80% after deductible	$250 per day up to 5 day maximum	80% after deductible	100% after $250 copay per day / up to 5 days
Room and Board	100%	80% after deductible	100%	80% after deductible	100%
Pre-admission Testing	100%	80% after deductible	100%	80% after deductible	100%
Surgery in Hospital	100%	80% after deductible	100%	80% after deductible	100%
Inpatient Physician Services	100%	80% after deductible	100%	80% after deductible	100%
Outpatient Dept. Services	100%	80% after deductible	100%	80% after deductible	100%
Emergency Care					
Emergency Room	100% after $25 copay		100% after $100 facility copay	$100 facility copay then deductible then 80%	100% after $100 facility payment
	Payment at the in-network level across-the-board applies only to true Medical Emergencies and Accidental Injuries.		**Payment at the in-network level across-the-board applies only to true Medical Emergencies and Accidental Injuries.**		**Payment at the in-network level across-the-board applies only to true Medical Emergencies and Accidental Injuries.**
Ambulance	80% after deductible	80% after deductible	100%	80% after deductible	100%
Outpatient Surgery					

	Current Plan - Blue Card PPO Design 1		OMNIA Design 3		Advantage EPO Design 1
Benefit	**In-Network**	**Out-of-Network**	**TIER 1**	**TIER 2**	**In-Network ONLY**
Hopital Outpatient Surgery	100%	80% after deductible	$150 copayment	80% after deductible	100% after $200 copay
Surgery in an Ambulatory SurgiCenter	100%	80% after deductible	$100 copayment	80% after deductible	100% after $100 copay
Mental Health Services					
Inpatient	100%	80% after deductible	$250 per day up to 5 day maximum	80% after deductible	100% after $250 copay per day /up to 5 days
Outpatient department	100%	80% after deductible	100% after $15 copay	80% after deductible	100%
Office Setting	100% after $15 copay	80% after deductible	100% after $25 copay	100% after $30 copay	100% after $40 copay
Substance Abuse Services					
Inpatient	100%	80% after deductible	$250 per day up to 5 day maximum	80% after deductible	100% after $250 copay per day /up to 5 days
Outpatient department	100%	80% after deductible	100% after $15 copay	80% after deductible	100%
Office Setting	100% after $15 copay	80% after deductible	100% after $25 copay	100% after $30 copay	100% after $40 copay
Alcohol Abuse Services					
Inpatient	100%	80% after deductible	$250 per day up to 5 day maximum	80% after deductible	100% after $250 copay per day/(up to 5 days
Outpatient department	100%	80% after deductible	100% after $15 copay	80% after deductible	100%
Office Setting	100% after $15 copay	80% after deductible	100% after $25 copay	100% after $30 copay	100% after $40 copay
	ALL INPATIENT AND OUTPATIENT MENTAL HEALTH /SUBSTANCE ABUSE /ALCHOLISM SERVICES MUST BE COORDINATED THROUGH VALUE OPTIONS AT 1-800-626-2212.				
Other Services					
Bariatric Surgery	100%	80% after deductible	100%	80% after deductible	100%
Diabetic Education	100% after $15 copay	80% after deductible	100% after office copay	100% after office copay	100% after office copayment
Diabetic Supplies	80% after deductible	80% after deductible	100%	100%	100%
Durable Medical Equipment	80% after deductible	80% after deductible	100%	100%	50%
Home Health Care	100%	80% after deductible	100% after $5 copay	100% after $5 copay	100%
Hospice Care	100%	80% after deductible	$250 per day up to 5 day maximum	$250 per day up to 5 day maximum	100%
Infertility (including in-vitro ferilization)	100% after $15 copay	80% after deductible	100% after $15 copay office 100% after $15 copay outpatient	100% after $30 copay office 80% after deductible outpatient	100% after copayment in office setting, 100% in outpatient facility Limited to 4 egg retrievals per lifetime.
	Limited to 4 egg retrievals per lifetime.		Limited to 4 egg retrievals per lifetime.		
Orthotics and Prosthetics	100% after $15 copay	80% after deductible	100% after $20 copay	100% after $20 copay	100% after $20 copay
Physical Rehabilitation Facility Inpatient Services	100%	80% after deductible	$250 per day up to 5 day maximum	80% after deductible	100% Limited to 60 days per benefit period.
Private Duty Nursing	80% after deductible	80% after deductible	100%	80% after deductible	100% Limited to 30 visit per benefit period
	Limited to 240 hours per benefit period		Limited to 30 visits per benefit period (8-hours shifts)		
Short-term Therapies: Physical, Occupational, Speech, Respiratory	100% limited to 60 visits per benefit period, combined in and out of network	80% after deductible limited to 60 visits per benefit period, combined in and out of network	100% after $5 copay-office 100% after deductible-outpatient 30 Visit maximum per therapy, per benefit period, combined in and out of network	100% after $20 copay-office 80% after deductible-outpatient 30 Visit maximum per therapy, per benefit period, combined in and out of network	100% after $20 copay 30 visit maximum per therapy per BP.
Skilled Nursing Facility/Extended Care Center	100% up to 120 days with up to 120 days combined in & out of network	80% after deductible up to 120 days combined in & out of network	$250 per day up to 5 day maximum Limited to 100 days per benefit period combined in and out of network	$250 per day up to 5 day maximum Limited to 100 days per benefit period combined in and out of network	100% Limited to 100 days per benefit period.
Therapeutic Manipulation Chiropractic Care)	100%	80% after deductible	100% after $15 copay	100% after $30 copay	100% after $20 copay 25 visit maximum per benefit period.
	60 visit maximum per benefit period		25 visit maximum per benefit period		
Vision - Routine Eye Exam	Not Covered	Not Covered	Adult - Not Covered Pediatric - 1 Routine vision per year		100% after $40 copay
Vision Hardware	Not Covered		Adult - Not Covered Pediatric - Hardware Services up to $120 per year		$50 every two years
Prescription Drugs	Covered under freestanding program		Covered under freestanding program		Covered under freestanding progeram
Coordination of Benefits	Yes		Yes		Yes

***This summary highlights the major features of the above health benefit programs. 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 booklet for more information.