# OMNIA Silver BlueCard (G4646)

| Product Catalog Attribute: | Description | |
|---|---|---|
| Plan Name: | **OMNIA Silver BlueCard (G4646)** | |
| Plan Type: | OMNIA | OMNIA |
| Monthly Cost: | See Rate Table | See Rate Table |
| **Network:** | **OMNIA Tier 1** | **Tier 2** |
| Coinsurance: | 40% Coinsurance | 50% Coinsurance |
| **Annual Deductible:** | | |
| Individual: | $2,450 Deductible | $2,500 Deductible |
| Family: | $4,900 Deductible | $5,000 Deductible |
| **Maximum Out-of-Pocket Limit:** | | |
| Individual: | $9,200 Out-of-Pocket Limit | $9,200 Out-of-Pocket Limit |
| Family: | $18,400 Out-of-Pocket Limit | $18,400 Out-of-Pocket Limit |
| Lifetime Maximum: | Unlimited | Unlimited |
| **Physicians:** | | |
| Office Visit for Primary Doctor: | $30 Copayment per visit | $40 Copayment per visit |
| Office Visit for Specialist: | $50 Copayment per visit | $60 Copayment per visit |
| Primary Care Physician (PCP) Required: | No | No |
| Specialist Referrals Required: | No | No |
| Preventive Care: | No charge | No charge |
| **Prescription Drug Coverage** | | |
| Generic Prescription Drugs: | $25 Copayment after deductible | $25 Copayment after deductible |
| Brand Prescription Drugs: | 50% Coinsurance after deductible | 50% Coinsurance after deductible |
| Non-Formulary Prescription Drugs: | 50% Coinsurance after deductible | 50% Coinsurance after deductible |
| Separate Prescription Drug Deductible | Individual: $250 Deductible<br>Family: $500 Deductible | Individual: $250 Deductible<br>Family: $500 Deductible |
| Mail Order for Prescription Drugs: | Generic: $50 Copayment after deductible<br>Preferred Brand: 50% Coinsurance after deductible<br>Non-Preferred Brand: 50% Coinsurance after deductible | Generic: $50 Copayment after deductible<br>Preferred Brand: 50% Coinsurance after deductible<br>Non-Preferred Brand: 50% Coinsurance after deductible |
| **Hospital Services Coverage:** | **OMNIA Tier 1** | **Tier 2** |
| Emergency Room: | $100 Copayment and 40% Coinsurance after deductible | $100 Copayment and 40% Coinsurance after deductible |
| Laboratory (Non-Routine): | Outpatient: 40% Coinsurance after deductible | 50% Coinsurance after deductible |
| Radiology Services (Non-Preventive): | Outpatient: 40% Coinsurance after deductible | 50% Coinsurance after deductible |
| Surgery: | Ambulatory Surgery Center: 30% Coinsurance after deductible<br>Outpatient Facility: 40% Coinsurance after deductible | 50% Coinsurance after deductible |
| Hospitalization (*Subject to Pre-approval. Includes Biologically Based Mental Illness)* : | 40% Coinsurance after deductible | 50% Coinsurance after deductible |
| **Maternity Coverage** | | |
| Pre & Postnatal Office Visit: | $50 Copayment | $60 Copayment |
| Labor & Delivery Hospital Stay: | 40% Coinsurance after deductible | 50% Coinsurance after deductible |
| **Additional Coverage** | **Tier 1** | **Tier 2** |
| Routine Eye Exam - Adult: | No Charge when rendered by a PCP | No Charge when rendered by a PCP |
| Routine Eye Exam - Child: | No Charge | No Charge |
| Chiropractic Coverage (*Limited to 30 visits per calendar year* ): | $30 Copayment per visit | $30 Copayment per visit |
| Physical Therapy *(Limited to 30 visits per calendar year):* | Office Visit: $30 Copayment<br>Outpatient: 40% Coinsurance after deductible | Office Visit: $40 Copayment<br>Outpatient: 50% Coinsurance after deductible |
| Mental Health Coverage (Non-Biologically Based Mental Illness): | Office Visit: $30 Copayment<br>Outpatient: 40% Coinsurance after deductible | Office Visit: $40 Copayment<br>Outpatient: 50% Coinsurance after deductible |
| Substance Abuse Coverage: | Office Visit: $30 Copayment<br>Outpatient: 40% Coinsurance after deductible | Office Visit: $40 Copayment<br>Outpatient: 50% Coinsurance after deductible |
| Exclusions and Limitations: | See Summary of Benefits and Coverage | See Summary of Benefits and Coverage |
| Disclaimers: | *This chart is only for illustrative purposes. Once you are enrolled, a complete list of details and exclusions will be provided in your individual contract/policy or Evidence of Coverage. | *This chart is only for illustrative purposes. Once you are enrolled, a complete list of details and exclusions will be provided in your individual contract/policy or Evidence of Coverage. |
| **Office Visit Copay:** | $30 Copay /$50 Copay | $40 Copay /$60 Copay |