



HORIZON ADVANTAGE EPO GOLD 100 \$25/\$45 BLUECARD® (G4540)

Product Catalog Attribute:	Description	
Plan Name:	Horizon Advantage EPO Gold 100 \$25/\$45 BlueCard (G4540)	
Plan Type:	Advantage EPO	Advantage EPO
Monthly Cost:	See Rate Table	
Network:	In Network	Out of Network
Coinsurance:	0% Coinsurance	Not covered
Annual Deductible:		
Individual:	No Deductible	Not covered
Family:	No Deductible	Not covered
Maximum Out-of-Pocket Limit:		
Individual:	\$7,000 Out-of-Pocket Limit	Not covered
Family:	\$14,000 Out-of-Pocket Limit	Not covered
Lifetime Maximum:	Unlimited	Not covered
Physicians:		
Office Visit for Primary Doctor:	\$25 Copayment per visit	Not covered
Office Visit for Specialist:	\$45 Copayment per visit	Not covered
Primary Care Physician (PCP) Required:	No	Not covered
Specialist Referrals Required:	No	Not covered
Preventive Care:	No charge	Not covered
Prescription Drug Coverage		
Generic Prescription Drugs:	\$25 Copayment	Not covered
Brand Prescription Drugs:	\$50 Copayment	Not covered
Non-Formulary Prescription Drugs:	\$75 Copayment	Not covered
Mail Order for Prescription Drugs:	Generic: \$50 Copay Preferred Brand: \$100 Copay Non-Preferred Brand: \$150 Copay	Not covered
Separate Prescription Drug Deductible	None	None
Hospital Services Coverage:	In Network	Out of Network
Emergency Room:	\$100 Copayment per visit	Not covered
Laboratory (Non-Routine):	Outpatient: \$100 Copayment	Not covered
Radiology Services (Non-Preventive):	Outpatient: \$100 Copayment	Not covered
Surgery:	Inpatient - \$500 Copayment per day Outpatient - \$250 Copayment	Not covered
Hospitalization (<i>Subject to Pre-approval. Includes Biologically Based Mental Illness</i>):	\$500 Copayment per day (with maximum of \$2,500 per admission). <i>Waived if re-admitted within 90 days for same diagnosis</i>	Not covered
Maternity Coverage		
Pre & Postnatal Office Visit:	\$45 Copayment	Not covered
Labor & Delivery Hospital Stay:	\$500 Copayment per day	Not covered
Additional Coverage	In Network	Out of Network
Routine Eye Exam - Adult:	No Charge	Not covered
Routine Eye Exam - Child:	No Charge	Not covered
Chiropractic Coverage (<i>Limited to 30 visits per calendar year</i>):	\$25 Copayment per visit	Not covered
Physical Therapy (<i>Limited to 30 visits per calendar year</i>):	Office Visit - \$25 Copayment Outpatient - \$45 Copayment	Not covered
Mental Health Coverage (Non-Biologically Based Mental Illness):	Office Visit - \$25 Copayment Outpatient - \$25 Copayment	Not covered
Substance Abuse Coverage:	Office Visit - \$25 Copayment Outpatient - \$25 Copayment	Not covered
Exclusions and Limitations:	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:	\$25/\$45 Copay	Not covered

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