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	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 (*Subject to Pre-approval. Includes Biologically Based Mental Illness)*	$500 Copayment per day (with maximum of $2,500 per admission). *Waived if re-admitted within 90 days for same diagnosis*	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 (*Limited to 30 visits per calendar year*):	$25 Copayment per visit	Not covered
Physical Therapy *(Limited to 30 visits per calendar year):*	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	Not covered
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