Horizon Advantage EPO Gold 100 $25/$45 BlueCard (G4704)

Product Catalog Attribute:	**Description**	
Plan Name:	**Horizon Advantage EPO Gold 100 $25/$45 BlueCard (G4704)**	
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:	$7,550 Out-of-Pocket Limit	Not covered
Family:	$15,100 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:	30% Coinsurance	Not covered
Non-Formulary Prescription Drugs:	30% Coinsurance	Not covered
Mail Order for Prescription Drugs:	Generic: $50 Copayment Preferred Brand: 30% Coinsurance Non-Preferred Brand: 30% Coinsurance	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:	Ambulatory Surgery Center: $200 Copayment Outpatient Facility: $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

This document is for informational purposes only and does not constitute a binding agreement. The information provided by this document is not intended to replace or modify the terms, conditions, limitations, and exclusions contained within health, dental or vision benefit plans issued or administered by Horizon. In the event of a conflict between the information contained in this document and your plan documents, your plan documents shall control. Horizon Blue Cross Blue Shield of New Jersey is an independent licensee of the Blue Cross Blue Shield Association. The Blue Cross® and Blue Shield® names and symbols are registered marks of the Blue Cross Blue Shield Association. The Horizon® name and symbols are registered marks of Horizon Blue Cross Blue Shield of New Jersey. © 2024 Horizon Blue Cross Blue Shield of New Jersey, Three Penn Plaza East, Newark, New Jersey 07105.