Advantage EPO DESIGN 2
CPC Integrated Health *7/1/25-6/30/26*

Benefit	In-Network Benefits Only (Includes Bluecard network)
Benefit Period	Plan year
Deductible	
Individual	$1,000
Family	Two deductibles per family
Coinsurance	100/80%
Maximum Out of Pocket	
Individual	$3,500
Family	$7,000
Consolidated Maximum Out of Pocket is Plan year. The deductible, coinsurance, prescription, and copayments apply to the Maximum Out of Pocket.	
Benefit Period Maximum	Unlimited
Lifetime Maximum	Unlimited
Primary Care Physician Selection	Not Required
Doctor's Office Visits	
Primary Care Office Visit	100% after $20 copay A primary care physician is a general or family practitioner, internist or pediatrician
Specialist Office Visit	100% after $40 copay A referral is not required to visit a specialist.
Maternity Visits	100% after $40 copay Copay applies to 1st visit only Dependent children are ineligible for Maternity/Obstetrical Benefits.
Allergy Testing and Treatment	100% 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%
Well Child Exams	100%
Well Child Immunizations and Lead Screening	100%
Diagnostic Procedures	
Laboratory	100% in office setting or in a Preferred Lab 80% after deductible in outpatient facility
Outpatient X-ray/Radiology Services	100% in office setting 80% after deductible in outpatient facility
CT/CTA Scans, Pet Scans, MRIs/MRAs, Nuclear Medicine studies (including Nuclear Cardiology) require prior authorization. Advanced/Complex Radiology may pay at a different benefit level than listed above. The ordering physician should request the prior authorization by calling eviCore healthcare at **1-866-496-6200** and providing the necessary clinical information. Once the authorization number is received, the member may call eviCore healthcare at **1-866-969-1234** to schedule an appointment. *Note: Managed Care members can call **1-866-969-1234** to obtain a confirmation number for non-Advanced Imaging diagnostic procedures. Confirmation*	
Hospital Care	
Inpatient Admission (including maternity)	80% after deductible
Pre-admission Testing	80% after deductible
Surgery in Hospital	80% after deductible
Inpatient Physician Services	80% after deductible
Outpatient Dept. Services	80% after deductible
Emergency Care	
Emergency Room	80% after $100 facility copay
Ambulance	80% after deductible

Advantage EPO DESIGN 2

Outpatient Surgery	
Hospital Outpatient Surgery	80% after deductible
Surgery in an Ambulatory SurgiCenter	80% after deductible
Mental Health Services	
Inpatient	80% after deductible
Outpatient department	80% after deductible
Office setting	100% after $40 copay
Substance Abuse Services	
Inpatient	80% after deductible
Outpatient department	80% after deductible
Office setting	100% after $40 copay
Alcohol Abuse Services	
Inpatient	80% after deductible
Outpatient department	80% after deductible
Office setting	100% after $40 copay
	Inpatient and Outpatient Mental Health/Substance Abuse/Alcoholism Services must be coordinated through Horizon Behavioral Health at 1-800-626-2212.
Other Services	
Acupuncture	Not covered
Bariatric Surgery	80% after deductible
Diabetic Education	100% after office copayment
Diabetic Supplies	80% after deductible
Durable Medical Equipment	80% after deductible
Orthotics and Prosthetics (Per NJ mandate)	100% after $20 copay
Home Health Care	80% after deductible
Hospice Care	80% after deductible
Infertility (including in-vitro fertilization)	100% after copayment in office setting 80% after deductible in outpatient facility Limited to 4 egg retrievals per lifetime
Physical Rehabilitation Facility Inpatient Services	80% after deductible Limited to 60 days per benefit period
Private Duty Nursing	80% after deductible Limited to 30 visits per benefit period (8-hour shifts)
Short-term Therapies: Physical, Occupational, Speech, Respiratory	100% after office copayment 30 visit maximum per therapy, per benefit period
Skilled Nursing Facility/Extended Care Center	80% after deductible Limited to 100 days per benefit period
Therapeutic Manipulation (Chiropractic Care)	100% after office copayment 25 visit maximum per benefit period
Vision - Routine Eye Exam	100% after $40 copay
Vision Hardware	$50 every two years
Telemedicine	100% after $15 copay
Prescription Drugs	Covered under a freestanding prescription program
Eligibility	Dependent children, including full-time students, are covered until the end of the calendar year in which they reach the age of 26. Handicapped dependents are covered beyond the child removal age, if the handicap occurred prior to the age of 26. Under certain conditions, coverage may be extended for qualified dependents up to age 31.
Pre-Existing Conditions	Not applicable
Prior Authorization	Some services/procedures require prior authorization. For a complete list, contact our customer service number at 1-800-355-BLUE (2583) or refer to our website at **www.HorizonBlue.com**.
24/7 Nurse Line	24/7 Nurse Line is a health information service that includes a toll free 24 hour health information line staffed

Advantage EPO DESIGN 2

The Advantage EPO plans cover eligible expenses rendered by providers in Horizon's Managed Care network. When you utilize participating providers, you generally only pay your copayment and any applicable in-network coinsurance or deductible. No benefits are available out-of-network, except in emergency situations.

This summary highlights the major features of your health benefit program. 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 benefit booklet for more information.

I represent that by signing this document that I have the legal authority to accept these terms.

Group Official:

Signature: _____

Print: _____

Title: _____

Date: _____