Plan Provisions	Horizon Direct Access EO Plan		Horizon EPO DE Plan	Horizon EPO FE Plan
	Network: Direct Access		Network: EPO	Network: EPO
	In-Network	Out-of-Network	In-Network Only	In-Network Only
Annual Deductible (Individual/Family)	$500/$1,000	$2,000/$4,000	$1,000/$2,000	$2,000/$4,000
Out-of-Pocket Maximum (Includes Deductible)	$3,000/$6,000	$7,000/$14,000	$3,500/$7,000	$7,000/$14,000
Coinsurance	10%	30%	20%	30%
Preventive Care	100%	30%	100%	100%
Primary/Specialist Physician Office Visit	$25/$50 copay	30%*	$20/$40 copay	$30/$60 copay
Radiology	100% in office 10%* outpatient	30%*	100% in office 20%* outpatient	100% in office 30%* outpatient
Laboratory	100% in office 10%* outpatient	30%*	100% in office 20%* outpatient	100% in office 30%* outpatient
Hospital Care	10%*	30%*	20%*	30%*
Outpatient Surgery	10%*	30%*	20%*	30%*
Urgent Care	$50 copay	30%*	$40 copay	$60 copay
Emergency Care	$100 copay per visit, then 10% waived if admitted		$100 copay per visit, then 20% waived if admitted	$100 copay per visit, then 30% waived if admitted
Retail Prescription Drugs (30-day supply) •Tier 1 •Tier 2 •Tier 3	$15 copay $50 copay $75 copay	Not covered	$15 copay $50 copay $75 copay	$15 copay $50 copay $75 copay
Mail Order Prescription Drugs (90-day supply) •Tier 1 •Tier 2 •Tier 3	$35 copay $125 copay $200 copay	N/A	$35 copay $125 copay $200 copay	$35 copay $125 copay $200 copay

**After deductible is met.*
Note: This is a summary only of your coverage.
In-network services are based on negotiated charges; out-of-network services are based on reasonable and customary (R&C) charges.