HORIZON APEX HEALTH & LIFE INSURANCE COMPANY

Corporate Headquarters: 4820 Corporate Drive, Suite 300, Dallas, TX 75201
Customer Service & Claims: 1-800-555-0199
Website: https://www.google.com/search?q=www.horizonapexhealth.com
Provider Services: 1-800-555-0200
24/7 Nurse Triage Line: 1-800-555-0911

PART I: DECLARATIONS PAGE

Policyholder Name: Jonathan A. Miller
Policyholder Address: 1428 Elm Street, Apt 4B, Austin, TX 78701
Policy Number: HAH-772901-84B
Group Number: IND-2026-TX
Plan Type: Preferred Provider Organization (PPO) - Gold Tier
Agent of Record: Sarah Jenkins, License #TX-99821A
Effective Date: January 1, 2026
Expiration Date: December 31, 2026
Coverage Tier: Individual
Monthly Premium: $485.50

Financial Responsibilities

- **Annual Deductible (In-Network):** $1,500
- **Annual Deductible (Out-of-Network):** $3,000
- **Annual Out-of-Pocket Maximum (In-Network):** $5,000
- **Annual Out-of-Pocket Maximum (Out-of-Network):** $10,000
- **Lifetime Maximum Benefit:** Unlimited (per Affordable Care Act guidelines)

THIS POLICY IS A LEGAL CONTRACT BETWEEN THE POLICYHOLDER AND HORIZON APEX HEALTH & LIFE INSURANCE COMPANY. PLEASE READ YOUR POLICY CAREFULLY.

PART II: SCHEDULE OF BENEFITS

This section outlines the financial cost-sharing for covered medical services. All Co-insurance amounts apply *after* the Annual Deductible has been met, unless otherwise stated.

Covered Service	In-Network Member Responsibility	Out-of-Network Member Responsibility	Limitations & Exceptions
Preventive Care & Screenings	$0 (Deductible Waived)	40% Co-insurance	Subject to age/gender guidelines
Primary Care Physician (PCP) Visit	$30 Copayment	40% Co-insurance	Virtual visits available at $10 Copay
Specialist Visit	$50 Copayment	40% Co-insurance	No referral required
Urgent Care Center	$50 Copayment	40% Co-insurance	Copay waived if admitted to hospital
Emergency Room Services	$250 Copayment + 20% Co-insurance	$250 Copayment + 20% Co-insurance	True emergencies processed as In-Network
Ambulance Services (Ground/Air)	$300 Copayment	$300 Copayment	Covered for emergencies only
Inpatient Hospital Stay	20% Co-insurance	40% Co-insurance	Prior authorization required
Outpatient Surgery	20% Co-insurance	40% Co-insurance	Prior authorization required
Diagnostic Tests (X-Ray, Blood Work)	$20 Copayment	40% Co-insurance	Must use approved laboratory
Advanced Imaging (MRI, CT, PET)	20% Co-insurance	40% Co-insurance	Prior authorization required
Maternity & Newborn Care	20% Co-insurance	40% Co-insurance	Initial prenatal visit $0 Copayment
Mental Health	$30 Copayment	40% Co-insurance	Up to 40 visits per

(Outpatient)			Benefit Year
Mental Health (Inpatient)	20% Co-insurance	40% Co-insurance	Prior authorization required
Physical/Occupational Therapy	$40 Copayment	40% Co-insurance	Maximum 30 combined visits per year
Durable Medical Equipment (DME)	20% Co-insurance	40% Co-insurance	Requires PCP prescription

Prescription Drug Coverage (Retail - 30 Day Supply / Mail Order - 90 Day Supply)

- **Tier 1 (Generic Drugs):** $15 Copayment Retail / $30 Copayment Mail Order
- **Tier 2 (Preferred Brand Drugs):** $45 Copayment Retail / $90 Copayment Mail Order
- **Tier 3 (Non-Preferred Brand Drugs):** $90 Copayment Retail / $180 Copayment Mail Order
- **Tier 4 (Specialty Drugs):** 20% Co-insurance (Prior Authorization Required, Retail 30-day only)

PART III: DEFINITIONS

1. **Allowed Amount:** The maximum amount on which payment is based for covered health care services. This may be called "eligible expense" or "negotiated rate."
2. **Co-insurance:** The percentage of allowed charges for Covered Services that the Insured is required to pay after the Annual Deductible has been satisfied.
3. **Copayment (Copay):** A fixed dollar amount the Insured must pay for certain Covered Services, usually at the time the service is rendered.
4. **Deductible:** The amount the Insured must pay for Covered Services in a Benefit Year before the Company begins to pay for Covered Services.
5. **Explanation of Benefits (EOB):** A statement sent by the health insurance company to covered individuals explaining what medical treatments and/or services were paid for on their behalf.
6. **Formulary:** A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits.
7. **In-Network Provider:** A physician, hospital, or other healthcare facility that has entered into a contractual agreement with Horizon Apex Health to provide services at negotiated rates.
8. **Medically Necessary:** Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms, and that meet accepted medical standards.
9. **Out-of-Pocket Maximum:** The maximum amount the Insured will pay for Copayments, Co-insurance, and Deductibles in a Benefit Year. Once met, the Company pays 100% of the Allowed Amount for Covered Services for the remainder of the year.
10. **Pre-Authorization (Prior Authorization):** A decision by the health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary.
11. **Usual, Customary, and Reasonable (UCR) Charge:** The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service, as determined solely by the Company's proprietary internal data.

PART IV: INSURING AGREEMENT

Subject to the terms, conditions, limitations, and exclusions of this Policy, Horizon Apex Health & Life Insurance Company ("the Company") agrees to pay for the Covered Services incurred by the Insured ("the Policyholder"). Coverage is provided only for services that are deemed Medically Necessary, listed in the Schedule of Benefits, and performed on or after the Effective Date and prior to the Expiration Date or Termination of this Policy. The Company retains the absolute and sole right to determine Medical Necessity based on its internal clinical criteria, regardless of the recommendations or prescriptions of the Insured's treating physician.

PART V: EXCLUSIONS AND LIMITATIONS

This Policy does not cover expenses incurred for the following, unless mandated by state or federal law:

1. **Cosmetic Services:** Surgery, procedures, or medications performed primarily to improve physical appearance, except for reconstructive surgery following a covered mastectomy or due to accidental injury.
2. **Experimental or Investigational Treatments:** Any medical procedure, equipment, treatment, or drug that has not been recognized as safe, effective, and standard of care by the American Medical Association or the U.S. Food and Drug Administration (FDA). The Company reserves the right to classify any newly approved FDA treatment as "Experimental" for up to 36 months post-approval.
3. **Dental and Vision Care:** Routine eye exams, eyeglasses, contact lenses, LASIK, routine dental care, orthodontics, and dentures, except as mandated by law for pediatric beneficiaries under age 19.
4. **Over-the-Counter (OTC) Medications:** Drugs, vitamins, and supplements available without a prescription, unless specifically covered under the Preventive Care mandate.
5. **Custodial & Long-Term Care:** Non-medical care that helps individuals with activities of daily living (e.g., bathing, dressing, feeding) at home or in a nursing facility.
6. **Weight Loss Programs:** Bariatric surgery, dietary supplements, and weight loss programs, unless specifically diagnosed as Medically Necessary for the treatment of morbid obesity and pre-approved by the Company.
7. **Fertility & Infertility Treatments:** In vitro fertilization (IVF), artificial insemination, reversal of voluntary sterilization, and related medications.
8. **Worker's Compensation:** Illnesses or injuries arising out of, or in the course of, any employment for wage or profit, which are covered by applicable Worker's Compensation laws.
9. **Acts of War or Military Service:** Treatment of injuries or illnesses sustained as a result of declared or undeclared war, or while on active duty in the armed forces.
10. **Alternative Medicine:** Acupuncture, holistic treatments, naturopathy, massage therapy, and homeopathy.

PART VI: CONDITIONS AND GENERAL PROVISIONS

1. **Notice of Claim:** Written notice of a claim must be given to the Company within ninety (90) days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible.
2. **Emergency Admission Notification:** In the event of an emergency hospital admission, the Insured, a family member, or the attending physician MUST notify the Company within twenty-four (24) hours of admission. Failure to provide notification within this strict timeframe will result in a complete denial of all inpatient hospital claims, regardless of Medical Necessity.
3. **Usual, Customary, and Reasonable (UCR) Limitations:** For Out-of-Network services, the Company will only pay up to the UCR charge. The UCR charge is calculated using the Company's proprietary formulas. The Insured is entirely responsible for "balance billing"—the difference between the provider's actual billed charge and the Company's determined UCR rate. Balance billed amounts do NOT count toward the Out-of-Pocket Maximum.
4. **Step Therapy Protocol ("Fail First" Requirement):** For certain prescription drugs and medical treatments, the Company requires the Insured to first try and fail a less expensive, Company-preferred alternative treatment before the Company will approve coverage for the treatment originally prescribed by the Insured's physician.
5. **Coordination of Benefits (COB):** If the Insured is covered under another valid health insurance plan, the Company will coordinate its benefit payments with the other plan to ensure that total payments do not exceed 100% of the allowable medical expenses.
6. **Prior Authorization:** Certain services, including but not limited to inpatient admissions, advanced imaging, and specialty surgeries, require prior approval from the Company. Failure to obtain Prior Authorization may result in a 50% reduction in benefits or complete denial of the claim.
7. **Grace Period:** A grace period of thirty (30) days will be granted for the payment of each premium falling due after the first premium. During this period, the Policy shall continue in force. If payment is not received by the end of the grace period, coverage will be retroactively terminated to the last paid date.
8. **Appeals and Grievances:** The Insured has the right to appeal any adverse benefit determination (claim denial). A written appeal must be submitted within 180 days of receiving the Notice of Denial. The Company will provide a full and fair review within 30 days for pre-service claims and 60 days for post-service claims.
9. **Subrogation and Reimbursement:** If the Insured receives benefits under this Policy for an injury caused by a third party (e.g., a motor vehicle accident), the Company reserves the right to recover the cost of those benefits from any settlement, judgment, or other payment the Insured receives from the third party.
10. **Right of Audit & Recoupment:** The Company reserves the right to audit medical records related to the services provided to the Insured to verify the Medical Necessity and appropriateness of billing codes. If the Company determines retroactively that a paid claim did not meet its strict Medical Necessity criteria, the Company reserves the right to recoup those funds directly from the Insured.
11. **Termination of Coverage:** Coverage under this Policy will terminate upon the earliest of the following:

- Non-payment of premiums beyond the grace period.

- Fraud or intentional misrepresentation of material fact by the Insured.
- The Insured no longer residing in the geographical service area.
- Written request by the Policyholder to cancel the Policy.

IN WITNESS WHEREOF, Horizon Apex Health & Life Insurance Company has caused this Policy to be signed by its authorized officers.

Signature on File

Eleanor V. Vance, Chief Executive Officer

Signature on File

Marcus T. Thorne, Corporate Secretary