# Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

**Horizon Healthcare Solutions: PPO Plan Coverage Period: 01/01/2025 – 12/31/2025 Coverage for: Individual/Family | Plan Type: PPO**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-888-555-0138 or visit www.horizonhealthcare.com (http://www.horizonhealthcare.com). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ (http://www.healthcare.gov/sbc-glossary/) or call 1-855-555-4448 to request a copy.

| Important Questions | Answers | Why This Matters: |
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| **What is the overall deductible?** | In-Network: $1,000 Individual / $2,000 Family<br>Out-of-Network: $2,000 Individual / $4,000 Family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
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| **Are there services covered before you meet your deductible?** | Yes. In-network preventive care, primary care visits, specialist visits, and prescription drugs are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. This plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | In-Network: $3,500 Individual / $7,000 Family<br>Out-of-Network: $7,000 Individual / $14,000 Family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

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| **Will you pay less if you use a network provider?** | Yes. See www.horizonhealthcare.com or call 1-888-555-0138 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| **Common Medical Event** | **Services You May Need** | **What You Will Pay** | | **Limitations, Exceptions, & Other Important Information** |
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| | | **In-Network Provider (You will pay the least)** | **Out-of-Network Provider (You will pay the most)** | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $25 copay/visit; deductible does not apply | 40% coinsurance | Virtual Primary Care: $15 copay/visit; deductible does not apply. See your benefit booklet* for details. |
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| | Specialist visit | $45 copay/visit; deductible does not apply | 40% coinsurance | None |
| | Preventive care/screening/ immunization | No Charge; deductible does not apply | 40% coinsurance | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | Preauthorization may be required; see your benefit booklet* for details. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | |
| **If you need drugs to treat your illness or condition**<br><br>More information about prescription drug coverage is available at www.horizonrx.com | Generic drugs | $10 copay/prescription (retail)<br>$25 copay/prescription (mail order); deductible does not apply | Not Covered | 30-day supply at Retail<br>90-day supply at Mail Order<br><br>Certain medications considered preventive care under ACA are payable at no cost-share to the member.<br><br>The difference in cost of brand drugs over available generic drugs is a non-covered penalty. The penalty is not subject to the deductible or out-of-pocket limits. |
| | Preferred brand drugs | $35 copay/prescription (retail)<br>$87.50 copay/prescription (mail order); deductible does not apply | Not Covered | |

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| | Non-preferred brand drugs | $60 copay/prescription (retail) $150 copay/prescription (mail order); deductible does not apply | Not Covered | |
| | Specialty drugs | $100 copay/prescription; deductible does not apply | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | Preauthorization may be required. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | $200 copay/visit plus 20% coinsurance | $200 copay/visit plus 20% coinsurance | Copay waived if admitted. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Preauthorization may be required for non-emergency transportation; see your benefit booklet* for details. |
| | Urgent care | $50 copay/visit; deductible does not apply | 40% coinsurance | None |

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| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Preauthorization required. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 copay/office visit; deductible does not apply<br>20% coinsurance for other outpatient services | 40% coinsurance | Virtual behavioral health visits: $15 copay/visit; deductible does not apply. Preauthorization may be required; see your benefit booklet* for details. |
| | Inpatient services | 20% coinsurance | 40% coinsurance | Preauthorization required. |
| **If you are pregnant** | Office visits | $25 copay/visit; deductible does not apply | 40% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | None |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | Preauthorization may be required. |

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| | Rehabilitation services | 20% coinsurance | 40% coinsurance | Limited to 60 visits combined per benefit period for occupational therapy, speech therapy and physical therapy. Preauthorization may be required. |
| | Habilitation services | 20% coinsurance | 40% coinsurance | |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | Limited to 60 days per benefit period. Preauthorization may be required. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | Benefits are limited to items used to serve a medical purpose. Durable Medical Equipment benefits are provided for both purchase and rental equipment (up to the purchase price). Preauthorization may be required. |
| | Hospice services | 20% coinsurance | 40% coinsurance | Preauthorization may be required. |
| **If your child needs dental or eye care** | Children's eye exam | Not Covered | Not Covered | Vision coverage available under separate plan. |
| | Children's glasses | Not Covered | Not Covered | Vision coverage available under separate plan. |
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| | Children's dental check-up | Not Covered | Not Covered | Dental coverage available under separate plan. |

**Excluded services & Other Covered Services:**

**Services Your Plan Generally Does NOT Cover** (Check your policy or plan document for more information and a list of any other excluded services.)

- Dental care (Adult, except for accident care)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (with the exception of person with diagnosis of diabetes)
- Weight loss programs

**Other Covered Services** (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (limited to 20 visits per calendar year)
- Bariatric surgery (for morbid obesity only)
- Chiropractic care (limited to 30 visits per calendar year)
- Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Hearing aids (limited to $2,500 per ear every 36 months)
- Infertility treatment (limited to 4 completed oocyte retrievals per lifetime)
- Most coverage provided outside the United States. See www.horizonhealthcare.com
- Private-duty nursing (with the exception of inpatient private duty nursing) (limited to 70 8-hour shifts per calendar year)

# Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-888-555-0138, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform (http://www.dol.gov/ebsa/healthreform), or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov (http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov (http://www.HealthCare.gov) or call 1-800-318-2596.

# Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Horizon Healthcare Solutions at 1-888-555-0138 or visit www.horizonhealthcare.com (http://www.horizonhealthcare.com), or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform (http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at (877) 527-9431 or visit http://insurance.illinois.gov (http://insurance.illinois.gov).

# Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

# Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

# Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-555-0138. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-555-0138. Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-555-0138. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-555-0138.

# About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

## Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible: $1,000
- Specialist copayment: $45
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

**Total Example Cost: $12,700**

In this example, Peg would pay:

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| Deductibles | $1,000 |
| Copayments | $500 |
| Coinsurance | $2,100 |
| What isn't covered - Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,660** |

## Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible: $1,000
- Specialist copayment: $45
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

**Total Example Cost: $5,600**

In this example, Joe would pay:

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| Deductibles | $800 |
| Copayments | $1,100 |
| Coinsurance | $350 |
| What isn't covered - Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,270** |

## Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible: $1,000
- Specialist copayment: $45
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

**Total Example Cost: $2,800**

In this example, Mia would pay:

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| Deductibles | $1,000 |
| Copayments | $500 |
| Coinsurance | $240 |
| What isn't covered - Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,740** |

The plan would be responsible for the other costs of these EXAMPLE covered services.