

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

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

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:
What is the overall deductible?	In-Network: \$3,200 Individual / \$6,000 Family Out-of-Network: \$6,400 Individual / \$12,000 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.

Are there services covered before you meet your deductible?	Yes. Certain preventive care is 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: \$6,100 Individual / \$12,200 Family Out-of-Network: \$12,200 Individual / \$24,400 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.

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
		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% coinsurance	45% coinsurance	Virtual Primary Care: 25% coinsurance/visit; deductible applies. See your benefit booklet* for details.

	Specialist visit	25% coinsurance	45% coinsurance	None
	Preventive care/screening/immunization	No Charge; deductible does not apply	45% 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)	25% coinsurance	45% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	25% coinsurance	45% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.horizonrx.com	Generic drugs	25% coinsurance	NA	After the deductible is met, you will pay the applicable coinsurance.
	Preferred brand drugs	25% coinsurance	NA	Out of pocket limit applies.
	Non-preferred brand drugs	25% coinsurance	NA	Certain medications considered preventive care under ACA are payable at no cost-share to the member and skip the deductible. In addition to ACA drugs, the plan has an expanded preventive list. Drugs on this list will bypass the deductible and pay at the applicable coinsurance. 90 Day supplies available at

	Specialty drugs	25% coinsurance	NA	Retail and Home Delivery pharmacies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	45% coinsurance	Preauthorization may be required.
	Physician/surgeon fees	25% coinsurance	45% coinsurance	None
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	None
	Emergency medical transportation	25% coinsurance	25% coinsurance	Preauthorization may be required for non-emergency transportation; see your benefit booklet* for details.
	Urgent care	25% coinsurance	45% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	45% coinsurance	Preauthorization required.
	Physician/surgeon fees	25% coinsurance	45% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance	45% coinsurance	Virtual Primary Care: 25% coinsurance/visit; deductible applies. See your benefit booklet* for details. Preauthorization may be required; see your benefit booklet* for details.

	Inpatient services	25% coinsurance	45% coinsurance	Preauthorization required.
If you are pregnant	Office visits	25% coinsurance	45% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	25% coinsurance	45% coinsurance	None
	Childbirth/delivery facility services	25% coinsurance	45% coinsurance	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	45% coinsurance	Preauthorization may be required.
	Rehabilitation services	25% coinsurance	45% coinsurance	Limited to 75 visits combined per benefit period for occupational therapy, speech therapy and physical therapy. Preauthorization may be required.
	Habilitation services	25% coinsurance	45% coinsurance	
	Skilled nursing care	25% coinsurance	45% coinsurance	Preauthorization may be required.

	Durable medical equipment	25% coinsurance	45% 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	25% coinsurance	45% coinsurance	Preauthorization may be required.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None
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.) <ul style="list-style-type: none"> • Dental care (Adult) • 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
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Hearing aids
- Infertility treatment
- Most coverage provided outside the United States. See www.horizonhealthcare.com
- Private-duty nursing (with the exception of inpatient private duty nursing) (unlimited visits 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, kwijigo 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: \$3,200
- Specialist coinsurance: 25%
- Hospital (facility) coinsurance: 25%
- Other coinsurance: 25%

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:

Deductibles	\$3,200
Copayments	\$0
Coinsurance	\$2,300
What isn't covered - Limits or exclusions	\$60
The total Peg would pay is	\$5,560

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible: \$3,200
- Specialist coinsurance: 25%
- Hospital (facility) coinsurance: 25%
- Other coinsurance: 25%

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:

Deductibles	\$3,200
Copayments	\$0
Coinsurance	\$600
What isn't covered - Limits or exclusions	\$20
The total Joe would pay is	\$3,820

Mia's Simple Fracture

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

- The plan's overall deductible: \$3,200
- Specialist coinsurance: 25%
- Hospital (facility) coinsurance: 25%
- Other coinsurance: 25%

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:

Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
What isn't covered - Limits or exclusions	\$0
The total Mia would pay is	\$2,800

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