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

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

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?	$500 Individual / $1,000 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. 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?	$2,500 Individual / $5,000 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 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. This plan does not cover services from out-of-network providers except in limited situations, such as emergency care.

Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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
		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	$20 copay/visit; deductible does not apply	Not Covered	Virtual Primary Care: $10 copay/visit; deductible does not apply.
	Specialist visit	$40 copay/visit; deductible does not apply	Not Covered	Referral required.
	Preventive care/screening/ immunization	No Charge; deductible does not apply	Not Covered	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)	10% coinsurance	Not Covered	Referral required.

	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not Covered	Referral and preauthorization required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.horizonrx.com	Generic drugs	$10 copay/prescription (retail) $20 copay/prescription (mail order); deductible does not apply	Not Covered	30-day supply at Retail 90-day supply at Mail Order Certain medications considered preventive care under ACA are payable at no cost-share to the member.
	Preferred brand drugs	$30 copay/prescription (retail) $60 copay/prescription (mail order); deductible does not apply	Not Covered	
	Non-preferred brand drugs	$50 copay/prescription (retail) $100 copay/prescription (mail order); deductible does not apply	Not Covered	
	Specialty drugs	$75 copay/prescription; deductible does not apply	Not Covered	

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not Covered	Referral and preauthorization required.
	Physician/surgeon fees	10% coinsurance	Not Covered	Referral required.
If you need immediate medical attention	Emergency room care	$150 copay/visit plus 10% coinsurance	$150 copay/visit plus 10% coinsurance	Copay waived if admitted.
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	$35 copay/visit; deductible does not apply	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not Covered	Referral and preauthorization required.
	Physician/surgeon fees	10% coinsurance	Not Covered	Referral required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/office visit; deductible does not apply 10% coinsurance for other outpatient services	Not Covered	Virtual behavioral health visits: $10 copay/visit; deductible does not apply. Preauthorization may be required.
	Inpatient services	10% coinsurance	Not Covered	Preauthorization required.

If you are pregnant	Office visits	$20 copay/visit; deductible does not apply	Not Covered	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	10% coinsurance	Not Covered	None
	Childbirth/delivery facility services	10% coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not Covered	Referral and preauthorization required.
	Rehabilitation services	$40 copay/visit; deductible does not apply	Not Covered	Limited to 60 visits combined per benefit period for occupational therapy, speech therapy and physical therapy. Referral required.
	Habilitation services	$40 copay/visit; deductible does not apply	Not Covered	
	Skilled nursing care	10% coinsurance	Not Covered	Limited to 60 days per benefit period. Referral and preauthorization required.

	Durable medical equipment	10% coinsurance	Not Covered	Referral required. 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).
	Hospice services	10% coinsurance	Not Covered	Referral and preauthorization required.
If your child needs dental or eye care	Children's eye exam	$40 copay/visit; deductible does not apply	Not Covered	Limited to 1 exam per calendar year.
	Children's glasses	No Charge up to $150; then 50% coinsurance	Not Covered	Limited to 1 pair of glasses per calendar year.
	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.)

- Acupuncture
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the service area
- Private-duty nursing
- 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.)

- Bariatric surgery
- Chiropractic care (limited to 20 visits per calendar year, referral required)
- 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 diagnosis and treatment of underlying medical condition)
- Routine eye care (Adult) (limited to 1 exam 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: $500
- Specialist copayment: $40
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 10%

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	$500
Copayments	$800
Coinsurance	$1,100
What isn't covered - Limits or exclusions	$60
The total Peg would pay is	**$2,460**

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible: $500
- Specialist copayment: $40
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 10%

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	$500
Copayments	$1,000
Coinsurance	$180
What isn't covered - Limits or exclusions	$20
The total Joe would pay is	**$1,700**

Mia's Simple Fracture

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

- The plan's overall deductible: $500
- Specialist copayment: $40
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 10%

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	$500
Copayments	$600
Coinsurance	$90
What isn't covered - Limits or exclusions	$0
The total Mia would pay is	**$1,190**

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