

DEDUCTIBLE AND ANNUAL OUT-OF-POCKET MAXIMUM	IMAGINE HEALTH	ALL OTHER FACILITY AND PHYSICIANS
<b>Calendar Year Deductible(aggregate)</b> (Includes Rx Expenses) - Employee Only - Family (Employee + 1 or More)	\$2,300 \$4,600	\$2,800 \$5,600
<b>Calendar Year Out-of-Pocket Maximum(aggregate)</b> (Includes Deductible and Rx Expenses) - Employee Only - Family (Employee + 1 or More)	\$4,100 \$8,200	\$5,600 \$11,200

UTILIZATION REVIEW (UR) PREAUTHORIZATION REQUIREMENTS	
<b>Utilization Review required for the following services:</b> - Inpatient Hospital/Facility Admissions - MRI/MRA and PET scans - Home Health Care - Other Specified Level 1 and Level 2 Services	25% Reduction in benefits  Non-compliance penalty applies for failure to notify Utilization Review.

**LEVEL I FACILITY BENEFITS – Payment Levels:**

This section applies to covered expenses for services rendered by Hospitals and other types of facilities.

BENEFIT PERCENTAGE FOR:	IMAGINE HEALTH FACILITY BENEFITS	ALL OTHER FACILITY BENEFITS 1)	MAXIMUM BENEFITS, LIMITS & PROVISIONS
<b>Inpatient Hospital Services</b>	80% after Deductible	70% after Deductible	UR Preauthorization Required
<b>Maternity Inpatient Hospital Services</b>	80% after Deductible	70% after Deductible	Contact Imagine360 for coordination of care.
<b>Routine Newborn Care Inpatient Hospital Services</b>	80% Deductible Waived	70% Deductible Waived	Payable under covered mother's claim. Baby must be added as a dependent within 31 days after birth to be eligible for this benefit.
<b>Skilled Nursing Facility</b>	80% after Deductible	70% after Deductible	UR Preauthorization Required Limited to 120 days per Calendar Year
<b>Rehabilitation Facility</b>	80% after Deductible	70% after Deductible	UR Preauthorization Required Limited to 120 days per Calendar Year.
<b>Hospital Services for Mental/ Nervous Disorders, Chemical Dependency, Drug and Substance Abuse</b> Inpatient/Residential Treatment Facilities	80% after Deductible	70% after Deductible	UR Preauthorization Required.
<b>Hospital Emergency Room</b> (All related charges)	100% after \$250 ER Copay		UR Preauthorization required if admitted
<b>Outpatient Surgical Facility</b>	80% after Deductible	70% after Deductible	
<b>Outpatient Therapy/Other Services</b> Physical/Speech/Occupational Therapy	100% after \$25 Copay	100% after \$50 Copay	Limited to 90 combined visits per calendar year.
Pulmonary/Cardiac Rehabilitation	100% after \$25 Copay	100% after \$50 Copay	
<b>Outpatient Diagnostic Services</b> Select Diagnostic Procedures (CT scans, MRIs, PET Scans, etc.)	80% after Deductible	70% after Deductible	UR Preauthorization required for

			MRI/MRA and PET scans.
<b>All Other Diagnostic Lab and X-ray</b>	No charge after Deductible (IH & Quest)	70% after Deductible	
<b>Preventive and Wellness Lab and X-ray</b>	100%; Deductible waived		

1) There is no PPO Hospital Network on this Plan. The PPO Network is a Physician Only PPO Network. Allowable Claim Limits apply to Hospital/Facility charges.

**LEVEL II PHYSICIAN BENEFITS – Payment Levels and Limits:** This section applies to Physicians and all other Providers of service not included as Facility Providers. Benefits shown are available based upon the Provider’s participation in the PPO network.

BENEFIT PERCENTAGE FOR:	IMAGINE HEALTH BENEFIT	ALL OTHER PHYSICIAN BENEFITS	MAXIMUM BENEFITS, LIMITS & PROVISIONS
<b>Physician Hospital Visits/Surgeon/Anesthesia</b>	80% after Deductible	70% after Deductible	
<b>Physician Hospital Visit for Mental &amp; Nervous Disorders/Chemical Dependency, Drug and Substance Abuse</b>	80% after Deductible	70% after Deductible	
<b>Maternity</b> (Including Prenatal delivery and Postnatal care)	80% after Deductible	70% after Deductible	Contact Imagine360 for coordination of care.
<b>Routine Newborn Care</b> (Pediatric care to date of mother’s discharge.)	80% Deductible Waived	70% Deductible Waived	Payable under covered mother’s claim. Baby must be added as a dependent within 31 days after birth to be eligible for this benefit.
<b>Office Visit</b> (includes Exam, treatment, office surgery)	100% after \$10 Copay (PCP) & \$25 Copay (Specialist)	100% after \$25 Copay (PCP) & \$50 Copay (Specialist)	
<b>Allergy Serum/Injections/Testing</b>	80% after Deductible	70% after Deductible	
<b>Mental/Nervous Disorders and Substance Abuse Office Visits</b>	100% after \$10 Copay	100% after \$25 Copay	
<b>Urgent Care Facility Physician Medical Care</b>	100% after \$25 Copay	100% after \$50 Copay	
<b>Recuro Health Telehealth</b> Virtual Urgent Care  Virtual Primary Care  Virtual Mental Health Services	100%; no Copay or Consultation Fee  100% after \$10 Copay  100% after \$10 Copay		<b>Call 844-715-1724 to schedule an appointment.</b>
<b>Chiropractic Services</b>	100% after \$25 Copay	100% after \$50 Copay	Limited to 30 visits per Calendar Year.
<b>Select Diagnostic Medical Procedures</b> CT Scans, MRIs, PET Scans, etc.(Physician’s Office or Freestanding Facility)	80% after Deductible	70% after Deductible	UR Preauthorization required for MRI/MRA and PET scans.
<b>All Other Diagnostic Lab/X-ray</b> (Freestanding Facility, Independent Lab, Physician’s office)	No charge after Deductible (IH & Quest)	70% after Deductible	
<b>Outpatient Therapy/Other Services</b> Physical/Speech//Occupational Therapy  Pulmonary/Cardiac Rehabilitation	100% after \$25 Copay  100% after \$25 Copay	100% after \$50 Copay  100% after \$50 Copay	Limited to 90 visits Combined per Calendar Year.

<b>Home Health Services</b>	80% after Deductible	70% after Deductible	UR Preauthorization Required Limited to 120 visits per Calendar Year
<b>Inpatient Hospice</b> (Home Hospice)	80% after Deductible	70% after Deductible	UR Preauthorization required
<b>Durable Medical Equipment</b>	80% after Deductible	70% after Deductible	UR Preauthorization Required For Equipment over \$1,500
<b>Prosthetic Devices and Orthotics</b>	80% after Deductible	70% after Deductible	Limited to 1 pair of foot orthotics per calendar year. Limited to a single purchase of each type of Prosthetic device every three calendar years.
<b>Ambulance Services Air &amp; Ground</b>	70% after Deductible		Contact Imagine360 for coordination of care.
<b>All Other Provider Covered Physician Services</b>	80% after Deductible	70% after Deductible	

- 2) Benefits shown in this summary apply to Imagine Health and Non – Imagine Health provider services.
- 3) Plan limits apply collectively/combined for Imagine Health and Non – Imagine Health services.

### Preventive and Wellness Care Benefits

This benefit is payable for Covered Procedures incurred as part of a Preventive and Wellness Care Program and is not payable for treatment of a diagnosed illness or injury. Services must be identified and billed as routine or part of a routine physical exam/or as specified below.

BENEFIT PERCENTAGE FOR:	IMAGINE HEALTH AND ALL OTHER PHYSICIANS	LIMITS & PROVISIONS
All Covered Wellness Benefits	100%; Copay/Deductible waived	See age and frequency limits and other special provisions below

#### Examples of Covered Wellness Procedures to include but are not limited to:

- 1) Routine Physical Exam
- 2) Annual Well Woman Exam
- 3) \*Annual Pap smear and other routine lab
- 4) \*Annual Routine Mammogram
- 5) \*Bone Density test
- 6) Annual PSA test (routine)
- 7) Well Baby Care Exam/Well Child Care Exam
- 8) Vision Screenings (to age 19)
- 9) Hearing Screenings for newborns
- 10) Routine Immunizations
- 11) Flu vaccine/pneumonia vaccine
- 12) \*Routine lab, x-ray, diagnostic testing and other medical screenings
- 13) Smoking/Tobacco Use Cessation
- 14) \*All FDA-approved Women's Contraceptive methods/Sterilization procedures
- 15) \*Routine Colonoscopy (includes polyp removal) – age 45 and older or family history of colon cancer

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- 2) Plan limits apply collectively/combined for Imagine Health and Non – Imagine Health services.

\* If these services are rendered by providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.

PRESCRIPTION DRUGS	
<b>The Plan Year Deductible must be satisfied before Pays</b>	
<b>Retail</b> (30-day supply)	Generic: \$10 Copay Preferred Brand: \$50 Copay Non-Preferred Brand: \$100 Copay
<b>Mail Order</b> (90-day supply)	Generic: \$25 Copay Preferred Brand: \$125 Copay Non-Preferred Brand: \$250 Copay
<b>Specialty Drugs</b> (30-day supply)	Applicable generic, preferred brand, or non- preferred brand coinsurance applies.

**NOTE:** This Summary of Benefits only represents an overview of your medical benefits and are subject to change.