

 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 Imagine360 at 1-800-903-4360. 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.cciio.cms.gov or call 1-800-903-4360 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible ? | \$2,000 Employee Only Level I & Level II MagnaCare PPO & Non-PPO | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. |
| Are there services covered before you meet your deductible ? | Yes. Preventive services do not apply towards the deductible . | This plan covers some items and services even if you haven't yet met the deductible amount. But a coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://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 ? | \$4,600 Employee Only Level I & Level II MagnaCare PPO & Non-PPO | The out-of-pocket limit is the most you could pay in a year for covered services. |
| What is not included in the out-of-pocket limit ? | Premiums; balance-billed charges; charges in excess of Allowable Claims Limits; any noncompliance penalties; 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 page 2 for an explanation of Level I & Level II Providers . Visit www.MagnaCare.com or a list of participating MagnaCare 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.
 Level I [Facilities](#) include but are not limited to: Hospitals (Inpatient and Outpatient treatment); Inpatient Facilities (such as Rehabilitation Facilities, Skilled Nursing Facilities and [Hospice](#)); Inpatient and Outpatient Facilities of Mental Disorders, Chemical Dependency, Drug and Substance Abuse; Ambulatory Surgery Centers and Dialysis Clinics
 Level II [Physicians](#) and all other [Providers](#) of service not defined as a Level I [Provider](#).

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|--|--|--|--|---|--|
| | | Level I Facilities | Level II PPO Physicians | Level II Non-PPO Physicians | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | N/A | 20% coinsurance ; deductible applies | | \$10 consult fee applies to Plans Telehealth/Telemedicine vendor Virtual Emergent & Urgent Care consultations. There is no charge for female office sterilization & all FDA approved contraceptive methods. 20% coinsurance (deductible applies) applies to Plans Telehealth/Telemedicine vendor Virtual Primary Care consultations. 20% coinsurance (deductible applies) applies to Plans Telehealth/Telemedicine vendor Virtual Mental Health consultations. Non-PPO charges are based on Allowable Claims Limits. |
| | Specialist visit | N/A | 20% coinsurance ; deductible applies | | |
| | Preventive care/screening/immunization | No Charge | | | |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% coinsurance ; deductible applies | | Level I & Non-PPO charges are based on Allowable Claims Limits. | |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance ; deductible applies | | UR notification required for MRI/MRA and PET scans or 25% benefit reduction non-compliance penalty applies. Level I & Non-PPO charges are based on Allowable Claims Limits. | |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|--|---|--|-----------------------------|--|
| | | Level I Facilities | Level II PPO Physicians | Level II Non-PPO Physicians | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medimpact.com | Generic drugs | Deductible then 20% coinsurance Retail & Mail Order | | | Covers a 30-day supply for Retail/90-day supply for Mail Order/30-day supply for Specialty. See your plan document for information about drugs that require prior authorization and drugs that are excluded. Coverage for specialty medications may be available through ArchimedesRX. |
| | Preferred brand drugs | Deductible then 20% coinsurance Retail & Mail Order | | | |
| | Non-preferred brand drugs | Deductible then 20% coinsurance Retail & Mail Order | | | |
| | Specialty drugs | Deductible then 20% coinsurance | | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance ; deductible applies | N/A | | UR notification required or 25% benefit reduction non-compliance penalty applies. Level I & Non-PPO charges are based on Allowable Claims Limits. |
| | Physician/surgeon fees | N/A | 20% coinsurance ; deductible applies | | |
| If you need immediate medical attention | Emergency room care | 20% coinsurance ; deductible applies | | | UR notification required if admitted inpatient or 25% benefit reduction non-compliance penalty applies. Level I & Non-PPO charges are based on Allowable Claims Limits. |
| | Emergency medical transportation | 20% coinsurance ; deductible applies | | | Level I & Non-PPO charges are based on Allowable Claims Limits. |
| | Urgent care | 20% coinsurance ; deductible applies | | | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance ; deductible applies | N/A | | UR notification required or 25% benefit reduction non-compliance penalty applies. Level I & Non-PPO charges are based on Allowable Claims Limits. |
| | Physician/surgeon fees | N/A | 20% coinsurance ; deductible applies | | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 20% coinsurance ; deductible applies | | | UR notification required for inpatient admissions and day treatment or 25% benefit reduction non-compliance penalty applies. Level I & Non-PPO charges are based on Allowable Claims Limits. |
| | Inpatient services | 20% coinsurance ; deductible applies | | | |
| If you are pregnant | Office visits | N/A | 20% coinsurance ; deductible applies | | Contact UR for coordination of care. Level I & Non-PPO charges are based on Allowable Claims Limits. |
| | Childbirth/delivery professional services | N/A | 20% coinsurance ; deductible applies | | |

[* For more information about limitations and exceptions, see the plan or policy document at mibenefits.imagine360.com.]

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|--|-------------------------|-----------------------------|---|
| | | Level I Facilities | Level II PPO Physicians | Level II Non-PPO Physicians | |
| | Childbirth/delivery facility services | 20% coinsurance ; deductible applies | N/A | | |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance ; deductible applies | | | Services are limited per calendar year to 120 visits for Home Health, 90 visits combined for Physical/Speech/ Occupational Therapy, 120 days for Skilled Nursing Facilities & 90 days for Rehabilitation Facilities. Treatment of developmental delays may not be covered. See your plan document for additional information. UR notification required for inpatient admission, Skilled Nursing/Rehabilitation Facility, Inpatient/Homebound Hospice, Home Health, All DME rentals and any purchase that exceeds \$1,500 or 25% benefit reduction non-compliance penalty applies. Level I & Non-PPO charges are based on Allowable Claims Limits. |
| | Rehabilitation services | 20% coinsurance ; deductible applies | | | |
| | Habilitation services | 20% coinsurance ; deductible applies | | | |
| | Skilled nursing care | 20% coinsurance ; deductible applies | | | |
| | Durable medical equipment | 20% coinsurance ; deductible applies | | | |
| | Hospice services | 20% coinsurance ; deductible applies | | | |
| If your child needs dental or eye care | Children's eye exam | No Charge | | | Benefit applies to routine vision screenings for children. Non-PPO charges are based on Allowable Claims Limits. |
| | Children's glasses | Not Covered | | | Not Covered |
| | Children's dental check-up | Not Covered | | | Not Covered |

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"> • Cosmetic Surgery • Dental Care (Adult) • Infertility Treatment | <ul style="list-style-type: none"> • Long Term Care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care • Weight Loss Programs |

[* For more information about limitations and exceptions, see the plan or policy document at mibenefits.imagine360.com.]

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

- Acupuncture
- Chiropractic Care
- Private Duty Nursing (Outpatient **only**)
- Bariatric Surgery
- Hearing Aids

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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 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: 800-903-4360 or the Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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:

Español: Para obtener asistencia en Español, llame al 800-903-4360

Tagalog: Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-903-4360

中文: 如果需要中文的帮助, 请拨打这个号码 800-903-4360

Dine: Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 800-903-4360

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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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 MultiPlan [deductible](#)
\$2,000
- [Specialist coinsurance](#) 20%
- [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:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$2,000 |
| Copayments | \$0 |
| Coinsurance | \$2,120 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$4,180 |

Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall MultiPlan [deductible](#)
\$2,000
- [Specialist coinsurance](#) 20%
- [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:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$2,000 |
| Copayments | \$0 |
| Coinsurance | \$690 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$2,710 |

Mia's Simple Fracture

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

- The [plan's](#) overall MultiPlan [deductible](#)
\$2,000
- [Specialist coinsurance](#) 20%
- [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:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$2,000 |
| Copayments | \$0 |
| Coinsurance | \$160 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,160 |