




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](http://www.cciio.cms.gov) or call 1-800-903-4360 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<b>\$2,800</b> person/ <b>\$5,600</b> family for Level I & Level II MagnaCare PPO & Non-PPO	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	<b>Yes.</b> <a href="#">Copayments</a> , prescriptions & preventive services do not apply towards the <a href="#">deductible</a>	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	<b>No.</b>	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<b>\$5,600</b> person/ <b>\$11,200</b> family for Level I & Level II MagnaCare PPO & Non-PPO	The <a href="#">out-of-pocket</a> limit is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	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 <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	<b>Yes.</b> See page 2 for an explanation of Level I & Level II <a href="#">Providers</a> . Visit <a href="http://www.MagnaCare.com">www.MagnaCare.com</a> for a list of participating MagnaCare <a href="#">providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .
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 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	N/A		\$25 <a href="#">copay</a> /visit; 0% <a href="#">coinsurance</a> ; <a href="#">deductible</a> waived	Family/General Practitioners, Pediatricians, Internists & Obstetrician/ Gynecologists are considered Primary Care Providers (PCP). PCP <a href="#">copay</a> applies to mental/behavioral & substance abuse office visits. There is no charge to Plans Telehealth/Telemedicine vendor Virtual Emergent & Urgent Care consultations, for female office sterilization & all FDA approved contraceptive methods. \$25 <a href="#">copay</a> /visit; 0% <a href="#">coinsurance</a> ( <a href="#">deductible</a> applies) applies to Plans Telehealth/ Telemedicine vendor Virtual Primary Care consultations. \$25 <a href="#">copay</a> /visit; 0% <a href="#">coinsurance</a> ( <a href="#">deductible</a> applies) applies to Plans Telehealth/Telemedicine vendor Virtual Mental Health consultations. 30% PPO & Non-PPO <a href="#">coinsurance</a> ; ( <a href="#">deductible</a> applies) applies for office allergy testing/ serums/ injections & x-ray/blood work. Non-PPO charges are based on Allowable Claims Limits.
	<a href="#">Specialist</a> visit	N/A		\$50 <a href="#">copay</a> /visit; 0% <a href="#">coinsurance</a> ; <a href="#">deductible</a> waived	

[\* For more information about limitations and exceptions, see the plan or policy document at [mibenefits.imagine360.com](http://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	
	<a href="#">Preventive care/screening/immunization</a>	No Charge			See your plan document for additional benefit information & limitations. Level I & Non-PPO charges are based on Allowable Claims Limits. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your plan will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies			Level I & Non-PPO charges are based on Allowable Claims Limits.
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> 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.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.medimpact.com">www.medimpact.com</a>	Generic drugs	<a href="#">Copays</a> : Retail \$10 (30-day supply) Mail Order \$25 (90-day supply)			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	<a href="#">Copays</a> : Retail \$50 (30-day supply) Mail Order \$125 (90-day supply)			
	Non-preferred brand drugs	<a href="#">Copays</a> : Retail \$100 (30-day supply) Mail Order \$250 (90-day supply)			
	<a href="#">Specialty drugs</a>	Retail <a href="#">copays</a> apply			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> 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	30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies		
If you need immediate medical attention	<a href="#">Emergency room care</a>	<b>Facility:</b> \$250 <a href="#">copay</a> /visit; 0% <a href="#">coinsurance</a> ; <a href="#">deductible</a> waived <b>Physicians:</b> No Charge			ER <a href="#">copay</a> waived if admitted inpatient. 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.

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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	
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies			Contact UR for coordination of care. Level I & Non-PPO charges are based on Allowable Claims Limits.
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit; 0% <a href="#">coinsurance</a> ; <a href="#">deductible</a> waived			Level I & Non-PPO charges are based on Allowable Claims Limits.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> 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	30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies		
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies			See ' <b>If you visit a health care provider's office or clinic</b> ' for the office visit benefit. 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	30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies			
<b>If you are pregnant</b>	Office visits	N/A	30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies		Office visit <a href="#">copayment</a> applies to the initial visit only. Contact UR for coordination of care. Level I & Non-PPO charges are based on Allowable Claims Limits.
	Childbirth/delivery professional services	N/A	30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies		
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies	N/A		
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies			Services are limited per calendar year to 120 visits for Home Health, 90 visits combined for Physical/Speech/Occupational Therapy, 120 combined days for Skilled Nursing/Rehabilitation Facilities & 60 visits for Private Duty Nursing. \$50 <a href="#">copay</a> /visit (0% <a href="#">coinsurance</a> ; <a href="#">deductible</a> waived) applies to Level I & Level II PPO & Non-PPO Cardiac/Pulmonary Rehab & Physical/Occupational/Speech Therapy.
	<a href="#">Rehabilitation services</a>	30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies			
	<a href="#">Habilitation services</a>	30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies			
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies			

[\* For more information about limitations and exceptions, see the plan or policy document at [mibenefits.imagine360.com](http://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	
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies			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.
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies			
<b>If your child needs dental or eye care</b>	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"> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> <li>• Infertility Treatment</li> </ul> | <ul style="list-style-type: none"> <li>• Long Term Care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> <li>• Weight Loss Programs</li> </ul> |
|--|--|---|

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

- |  |   |   |
|--|---|---|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric Surgery</li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic Care</li> <li>• Hearing Aids</li> </ul> | <ul style="list-style-type: none"> <li>• Private Duty Nursing (Outpatient <b>only</b>)</li> </ul> |
|--|---|---|

**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](http://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](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.

[\* For more information about limitations and exceptions, see the plan or policy document at [mibenefits.imagine360.com](http://mibenefits.imagine360.com).]

**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](http://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, kwijigo 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](#)  
\$2800
- [Specialist copay](#) \$50
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$2800
<a href="#">Copayments</a>	\$30
<a href="#">Coinsurance</a>	\$2,800
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,690</b>

### Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall MultiPlan [deductible](#)  
\$2800
- [Specialist copay](#) \$50
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$900
<a href="#">Copayments</a>	\$340
<a href="#">Coinsurance</a>	\$440
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,700</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall MultiPlan [deductible](#)  
\$2800
- [Specialist copay](#) \$50
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1310
<a href="#">Copayments</a>	\$550
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,860</b>