



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.ccio.cms.gov or call 1-800-903-4360 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$3,500 person/ \$7,000 family for 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. 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. Copayments , prescriptions & 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?	Yes, \$250 person/ \$500 family separate deductible applies for Retail Brand Name drugs	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$8,550 person/ \$17,100 family for 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. 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-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 for 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 .
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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 provider's office or clinic	Primary care visit to treat an injury or illness	N/A	\$25 copay /visit; 0% coinsurance ; deductible waived		Family/General Practitioners, Pediatricians, Internists & Obstetrician/ Gynecologists are considered Primary Care Providers (PCP). PCP copay applies to mental/behavioral & substance abuse office visits. There is no charge for female office sterilization & all FDA approved contraceptive methods. \$25 copay /visit; 0% coinsurance (Imagine deductible waived) applies to Plans Telehealth/ Telemedicine vendor Virtual Primary Care consultations. \$25 copay /visit; 0% coinsurance (Imagine deductible waived) applies to Plans Telehealth/Telemedicine vendor Virtual Mental Health consultations. 30% PPO & Non-PPO coinsurance ; (deductible applies) applies for office allergy testing/serums/ injections & x-ray/blood work. Non-PPO charges are based on Allowable Claims Limits.
	Specialist visit	N/A	\$50 copay /visit; 0% coinsurance ; deductible waived		
		Preventive care/screening/immunization	No Charge		

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 have a test	Diagnostic test (x-ray, blood work)	30% coinsurance ; deductible applies			Level I & Non-PPO charges are based on Allowable Claims Limits.
	Imaging (CT/PET scans, MRIs)	30% 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.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medimpact.com	Generic drugs	Coinsurance : Retail 30% (\$25 maximum) Mail Order 30% (\$62.50 maximum)			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	Rx Deductible then Coinsurance : Retail 30% (\$80 maximum) Coinsurance : Mail Order 30% (\$200 maximum)			
	Non-preferred brand drugs	Rx Deductible then Coinsurance : Retail 45% (\$130 maximum) Coinsurance : Mail Order 45% (\$325 maximum)			
	Specialty drugs	Generic drugs Coinsurance : 30% (\$25 maximum) Preferred brand drugs Coinsurance : 30% (\$80 maximum) Non-preferred brand drugs Coinsurance : 45% (\$130 maximum)			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% 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	30% coinsurance ; deductible applies		
If you need immediate medical attention	Emergency room care	Facility: \$500 copay /visit; 30% coinsurance ; deductible waived Physician: 30% coinsurance ; deductible waived			ER copay 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.
	Emergency medical transportation	20% coinsurance ; deductible applies			Contact UR for coordination of care. Level I & Non-PPO charges are based on Allowable Claims Limits.
	Urgent care	\$50 copay /visit; 0% coinsurance ; deductible waived			Level I & Non-PPO charges are based on Allowable Claims Limits.
If you have a hospital	Facility fee (e.g.,	30% coinsurance ;	N/A		UR notification required or 25% benefit

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	
stay	hospital room)	deductible applies			reduction non-compliance penalty applies. Level I & Non-PPO charges are based on Allowable Claims Limits.
	Physician/surgeon fees	N/A	30% coinsurance ; deductible applies		
If you need mental health, behavioral health, or substance abuse services	Outpatient services		30% coinsurance ; deductible applies		See 'If you visit a health care provider's office or clinic ' 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% coinsurance ; deductible applies		
If you are pregnant	Office visits	N/A	30% coinsurance ; deductible applies		Office visit copayment 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% coinsurance ; deductible applies		
	Childbirth/delivery facility services	30% coinsurance ; deductible applies		N/A	
If you need help recovering or have other special health needs	Home health care		30% coinsurance ; deductible 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 copay /visit (0% coinsurance ; deductible waived) applies to Level I & II PPO & Non-PPO Cardiac/ Pulmonary Rehabilitation & Physical/ Occupational/Speech Therapy. Treatment of developmental delays may not be covered. See your plan document for additional
	Rehabilitation services		30% coinsurance ; deductible applies		
	Habilitation services		30% coinsurance ; deductible applies		
	Skilled nursing care		30% coinsurance ; deductible applies		
	Durable medical equipment		30% coinsurance ; deductible applies		

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	
	Hospice services	30% coinsurance ; deductible applies			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.
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 .)			
• Cosmetic Surgery	• Long Term Care	• Routine eye care (Adult)	
• Dental Care (Adult)	• Non-emergency care when traveling outside the U.S.	• Routine foot care	
• Infertility Treatment		• Weight Loss Programs	
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, 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](#) \$3,500
- [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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles *	\$3,510
Copayments	\$0
Coinsurance	\$2,730
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$6,300

Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall MultiPlan [deductible](#) \$3,500
- [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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles *	\$1,150
Copayments	\$340
Coinsurance	\$980
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,490

Mia's Simple Fracture

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

- The [plan's](#) overall MultiPlan [deductible](#) \$3,500
- [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*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

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

*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?"