imagine360

BrightSpring Health Services

$2800 Deductible Plan – Multiplan Plus

Effective January 1, 2026
Group #H880335

DEDUCTIBLE AND ANNUAL OUT-OF-POCKET MAXIMUM	FACILITIES 1) PPO PHYSICIANS 2),3)
Calendar Year Deductible (aggregate) (includes Rx Expenses) - Employee Only - Family (Employee + 1 or More)	 $2,800 $5,600
Calendar Year Out-of-Pocket Maximum (aggregate) (includes Deductible and Rx Expenses) - Employee Only - Family (Employee + 1 or More)	 $5,600 $11,200

UTILIZATION REVIEW (UR) PREAUTHORIZATION REQUIREMENTS	
Utilization Review required for the following services: - 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:	FACILITY BENEFITS 1)	MAXIMUM BENEFITS, LIMITS & PROVISIONS
Inpatient Hospital Services	70% after Deductible	UR Preauthorization Required
Maternity Inpatient Hospital Services	70% after Deductible	Contact Imagine360 for coordination of care.
Routine Newborn Care Inpatient Hospital Services	70% Deductible Waived	
Skilled Nursing Facility	70% after Deductible	UR Preauthorization Required Limited to 120 days per Calendar Year
Rehabilitation Facility	70% after Deductible	UR Preauthorization Required Limited to 90 days per Calendar Year.
Hospital Services for Mental/ Nervous Disorders, Chemical Dependency, Drug and Substance Abuse Inpatient/Residential Treatment Facilities	70% after Deductible	UR Preauthorization Required.
Hospital Emergency Room (all related charges)	100% after $250 ER Copay	Contact Imagine360 for coordination of care.
Outpatient Surgical Facility	70% after Deductible	
Outpatient Therapy/Other Services Physical/Speech/Occupational Therapy Pulmonary/Cardiac Rehabilitation	 100% after $50 Copay 100% after $50 Copay	 Limited to 90 visits Combined per Calendar Year.
Outpatient Diagnostic Services Select Diagnostic Procedures (CT scans, MRIs, PET Scans, etc.)	70% after Deductible	UR Preauthorization required for MRI/MRA and PET scans.

All Other Diagnostic Lab/X-ray	70% after Deductible	
Preventive and Wellness Lab and X-ray	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:	LEVEL II PPO BENEFIT 2,3)	MAXIMUM BENEFITS, LIMITS & PROVISIONS
Physician Hospital Visits/Surgeon/Anesthesia	70% after Deductible	
Physician Hospital Visit for Mental & Nervous Disorders/Chemical Dependency, Drug and Substance Abuse	70% after Deductible	
Maternity (Including Prenatal delivery and Postnatal care)	70% after Deductible	Contact Imagine360 for coordination of care.
Routine Newborn Care (Pediatric care to date of mother's discharge.)	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.
Office Visit (includes Exam, treatment, treatment, Office surgery)	100% after $25 Copay (PCP) & $50 Copay (Specialist)	
Allergy Serum/Injections/Testing	70% after Deductible	
Mental/Nervous Disorders and Substance Abuse Office Visits	100% after $25 Copay	
Urgent Care Facility Physician Medical Care	100% after $50 Copay	
Recuro Health Telehealth Virtual Urgent Care Virtual Primary Care Virtual Mental Health Services	 100%; no Copay or Consultation Fee 100% after $25 Copay 100% after $25 Copay	**Call 844-715-1724 to schedule an appointment.**
Chiropractic Services	100% after $50 Copay	Limited to 30 visits per Calendar Year.
Select Diagnostic Medical Procedures CT Scans, MRIs, PET Scans, etc.(Physician's Office or Freestanding Facility)	70% after Deductible	UR Preauthorization required for MRI/MRA and PET scans.
All Other Diagnostic Lab/X-ray (Freestanding Facility, Independent Lab, Physician's office)	70% after Deductible	
Outpatient Therapy/Other Services Physical/Speech//Occupational Therapy Pulmonary/ Cardiac Rehabilitation	 100% after $50 Copay 100% after $50 Copay	Limited to 90 visits combined per Calendar Year.
Home Health Services	70% after Deductible	UR Preauthorization Required Limited to 120 visits per Calendar Year
Hospice (Inpatient and Home)	70% after Deductible	UR Preauthorization required
Durable Medical Equipment	70% after Deductible	UR Preauthorization Required For Equipment over $1,500

Prosthetic Devices and Orthotics	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
Ambulance Services **Air & Ground**	70% after Deductible	Contact Imagine360 for coordination of care.
All Other Provider Covered Physician Services	70% after Deductible	

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

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:	PHYSICIAN BENEFITS 2), 3), 4)	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) – age 40 and older
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) Annual Routine Vision Exam
14) Smoking/Tobacco Use Cessation
15) *All FDA-approved Women's Contraceptive methods/Sterilization procedures
16) *Routine Colonoscopy (includes polyp removal) – age 45 and older or family history of colon cancer

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

* 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	
The Plan Year Deductible must be satisfied before Pays	
Retail (30-day supply)	Generic: $10 Copay Preferred Brand: $50 Copay Non-Preferred Brand: $100 Copay
Mail Order (90-day supply)	Generic: $25 Copay Preferred Brand: $125 Copay Non-Preferred Brand: $250 Copay
Specialty Drugs (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.