imagine360

BrightSpring Health Services

$900 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 (embedded) - Per Covered Person - Family Limit	 $900 $1,800
Calendar Year Out-of-Pocket Maximum (embedded) (includes Deductible and all Copays) - Per Covered Person - Family Limit	 $4,000 $8,000

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	80% after Deductible	Prior Notification is Required.
Maternity Inpatient Hospital Services	80% after Deductible	Contact Imagine360 for coordination of care.
Routine Newborn Care Inpatient Hospital Services	80% 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.
Skilled Nursing Facility	80% after Deductible	Limited to 120 combined days per calendar year. Prior Notification is Required.
Rehabilitation Facility	80% after Deductible	Limited to 120 combined days per calendar year. Prior Notification is Required.
Hospital Services for Mental/ Nervous Disorders, Chemical Dependency, Drug and Substance Abuse Inpatient/Residential Treatment Facilities	80% after Deductible	Prior Notification Required
Hospital Emergency Room *Copay waived if admitted Inpatient* (all related charges)	$500 Copay	UR Preauthorization required if admitted inpatient.
Outpatient Surgical Facility	80% after Deductible	
Outpatient Therapy/Other Services Physical/Speech/Occupational Therapy Pulmonary/Cardiac Rehabilitation	 100% after $100 Copay 100% after $100 Copay	Limited to 90 visits combined per Calendar Year.

Outpatient Diagnostic Services Select Diagnostic Procedures (CT scans, MRIs, PET Scans, etc.)	80% after Deductible	UR Preauthorization required for MRI/MRA and PET scans.
All Other Diagnostic Lab/X-ray	80% 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	80% after Deductible	
Physician Hospital Visit for Mental & Nervous Disorders/Chemical Dependency, Drug and Substance Abuse	80% after Deductible	
Maternity (Including Prenatal delivery and Postnatal care) *OV Copay does not apply after initial visit.*	80% after Deductible	Contact Imagine360 for coordination of care.
Routine Newborn Care (Pediatric care to date of mother's discharge.)	80% Deductible Waived	Payable under covered mother's claim. Baby must be added as dependent within 31 days after birth to be eligible for this benefit.
Office Visit (includes Exam, treatment, Office surgery)	100% after $50 Copay (PCP) 100% after $100 Copay (Specialist)	
Allergy Serum/Injections/Testing	80% after Deductible	
Mental/Nervous Disorders and Substance Abuse Office Visits	100% after $50 Copay	
Urgent Care Facility Physician Medical Care	100% after $100 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 $100 Copay	Limited to 30 visits per Calendar Year.
Select Diagnostic Medical Procedures CT Scans, MRIs, PET Scans, etc.(Physician's Office or Freestanding Facility)	80% after Deductible	UR Preauthorization Required.
All Other Diagnostic Lab/X-ray (Freestanding Facility, Independent Lab, Physician's office)	80% after Deductible	
Outpatient Therapy/Other Services Physical/Speech/Occupational Therapy Pulmonary/ Cardiac Rehabilitation	 $100% after $100 Copay 100% after $100 Copay	Limited to 90 visits combined per Calendar Year.
Home Health Services	80% after Deductible	Prior Notification is Required Limited to 120 visits per Calendar Year
Hospice (Inpatient and Home)	80% after Deductible	Prior Notification is Required Or benefits reduced 25%

Durable Medical Equipment	80% after Deductible	Prior Notification is Required For Equipment over $1,500
Prosthetic Devices and Orthotics	80% after Deductible	Prior Notification is Required For Equipment over $1,500
Ambulance Services Air & Ground	80% after Deductible	Contact Imagine360 for coordination of care.
All Other Provider Covered Physician Services	80% 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 – age 40 and older
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	
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.