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 **(800) 827-7223** or visit www.Imagine360.com. 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 https://www.healthcare.gov/sbc-glossary or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 per covered person; $0 per family unit.	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. Preventive care, prescription drugs, and Recuro Health Telehealth are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or 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?	$9,100 per covered person or $18,200 per family unit.	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?	Prescription drug discounts and coupons, Pre-Service Review Penalties, Amounts over the allowable charge, premiums, balance-billing charges (unless balanced billing is prohibited), 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 www.imagine360.com or call 1-(800) 827-7223 for a list of network 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.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information*
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment per visit	The office visit copayment is limited to one per day and includes the office exam only.
	Specialist visit	$50 copayment per visit	
	Preventive care/screening/ immunization	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, then check what your plan will pay.
If you have a test	Diagnostic test (x-ray, blood work) Outpatient Hospital Facility Freestanding or Independent Facility	$150 copayment per test $50 copayment per service	None
	Imaging (CT/PET scans, MRIs)	$350 copayment per visit	Freestanding or Independent Facility only. Limited to 1 service per Plan Year. Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at your group's designated Pharmacy Benefit Manager (PBM) website.	Generic drugs	Preventive: No Charge $10 copayment/prescription (retail) $30 copayment/prescription (mail order)	Retail is available up to a 30-day supply per prescription and mail order drugs are available up to a 90-day supply per prescription. Copayments do not apply to preventive care drugs.
	Formulary brand name drugs	Not Covered	
	Non-formulary brand name drugs	Not Covered	
	Specialty drugs	Not covered	

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

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information*
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$350 copayment per visit	The outpatient copayment includes all services provided during the outpatient visit. Limited to 1 visit per Plan Year. Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.
	Physician/surgeon fees	$350 copayment per visit Copayment is waived if a Facility charge is also received.	Limited to 1 surgery per Plan Year.
If you need immediate medical attention	Emergency room care	$750 copayment per visit	Limited to 1 visit per Plan Year
	Urgent care	$75 copayment per visit	The Urgent Care copayment is limited to one per day and includes to all services provided during the Urgent Care visit.
	Emergency Medical Transportation	$500 copayment per transport	Land only. Limited to 1 transport per Plan Year
If you have a hospital stay	Facility fee (e.g., hospital room)	$750 copayment per admission	Limited to 5 days per Plan Year (Limits are combined with all inpatient admissions) Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.
	Physician/surgeon fees	$750 copayment per admission Copayment is waived if a Facility charge is also received.	Limited to 2 surgeries per Plan Year
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$75 copayment per visit	Limited to 8 visit per Plan Year. Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.
	Inpatient services	$750 copayment per admission Copayment is waived if a Facility charge is also received	Limited to 5 days per Plan Year. Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.
If you are pregnant	Office visits	$25 copayment per visit	There is no coverage of Pregnancy for a Dependent child other than Preventive Care services as required under the Affordable Care Act (ACA) for pregnant women. Subject to inpatient hospital stay limits. See "Hospital Stay" section for applicable day limits and pre-service review requirements.
	Childbirth/delivery professional services	$350 copayment per admission (Copayment applies in addition to facility copayment)	
	Childbirth/delivery facility services	$750 copayment per admission (inpatient hospital copayment also applies)	

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

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information*
If you need help recovering or have other special health needs	Home health care	$50 copayment per visit	Limited to 10 visits per plan year. Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.
	Rehabilitation services Inpatient Outpatient	$750 copayment per admission $75 copayment per visit	Inpatient is limited to Limited to 5 days per Plan Year. Outpatient Speech, Physical and Occupational Therapy is limited to a combined 8 visits per Plan Year. Pre-Service Review for Physical Therapy/Speech Therapy/Occupational Therapy (not including the initial evaluation) is required after 6 visits to prevent a penalty. Please refer to the Utilization Management section for more information.
	Skilled nursing care	Not Covered	No coverage available.
	Durable medical equipment	Not Covered	No coverage available.
	Hospice services	Not Covered	No coverage available.
If your child needs dental or eye care	Children's eye exam	Not covered	No coverage available
	Children's glasses	Not covered	
	Children's dental check-up	Not covered	No coverage available.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

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

- Chiropractic Care

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

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight 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 on how 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: Imagine360 at 800-827-7223. Additionally, a consumer assistance program may help with your appeal. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthcarereform and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance -Grants/.

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:
Spanish (Español): Para obtener asistencia en Español, llame al 800-827-7223.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-827-7223
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 800-827-7223
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-827-7223

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 deductible** **$0**
- **Primary care physician copayment** **$25**
- **Hospital (facility) copayment** **$750**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Primary care physician 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	$0
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,460**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well- controlled condition)

- **The plan's overall deductible** **$0**
- **Primary care physician copayment** **$25**
- **Hospital (facility) copayment** **$750**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Specialist 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	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$3,900
The total Joe would pay is	**$4,500**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Primary care physician copayment** **$25**
- **Hospital (facility) copayment** **$750**
- **Other coinsurance** **0%**

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	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Mia would pay is	**$800**

The plan would be responsible for the other costs of these EXAMPLE covered services.