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 844-843-07150 or visit https://www.mibenefits.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?	$3,400 individual / $6,800 family Each **JANUARY** a new deductible amount is required.	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 is 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?	$6,350 individual / $12,700 family	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, Pre-service review penalties, balance-billing charges (unless balance-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?	Not Applicable.	This plan does not use a provider network. You can receive covered services from any provider.
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	$30 copayment per visit, then 0% coinsurance	None.
	Specialist visit	$60 copayment per visit, then 0% coinsurance	None.
	Preventive care/screening/ immunization	No cost	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 for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	*Pre-Service Review is required to prevent a penalty.*

* 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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.veracity-rx.com..	Generic drugs	Preferred Pharmacy: Retail pharmacy: 34-day supply: $5 copayment/ 90-day supply: $12.50 copayment Mail order pharmacy: $12.50 copayment Non-Preferred Pharmacy: Retail pharmacy: 34-day supply: $10 copayment/ 90-day supply: Not covered Mail order pharmacy: Available through VeracityRx Mail Order Program	Deductible does apply to prescription drug coverage. Non-Preferred Pharmacies are CVS, Rite-Aid, Walgreens and Target. All other pharmacies are considered Preferred Pharmacies. Retail prescription fills are limited to a 90-day supply through a Preferred Pharmacy. Retail prescription fills are limited to a 34-day supply through a Non-Preferred Pharmacy. Mail order fills are limited to a 90-day supply through the Plan's mail order pharmacy.
	Preferred brand drugs	Preferred Pharmacy: Retail pharmacy: 34-day supply: $20 copayment / 90-day supply: $50 copayment Mail order pharmacy: $50 copayment Non-Preferred Pharmacy: Retail pharmacy: 34-day supply: $40 copayment / 90-day supply: Not covered Mail order pharmacy: Available through VeracityRx Mail Order Program	
	Non-preferred brand drugs	Preferred Pharmacy: Retail pharmacy: 34-day supply: $40 copayment / 90-day supply: $100 copayment Mail order pharmacy: $100 copayment Non- Preferred Pharmacy: Retail pharmacy: 34-day supply: $60 copayment / 90-day supply: Not covered Mail order pharmacy: Available through VeracityRx Mail Order Program	
	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)	20% coinsurance	*Pre-Service Review is required to prevent a penalty.*
	Physician/surgeon fees	20% coinsurance	None.
If you need immediate medical attention	Emergency room care	$200 copayment per visit, then 0% coinsurance	Copayment waived if admitted.
	Emergency medical transportation	0% coinsurance	None.
	Urgent care	$50 copayment per visit, then 0% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	*Pre-Service Review is required to prevent a penalty.*
	Physician/surgeon fees	20% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient physician's office: $60 copayment per visit, then 0% coinsurance All other outpatient providers: 20% coinsurance	None.
	Inpatient services	20% coinsurance	*Pre-Service Review is required to prevent a penalty.*
If you are pregnant	Office visits	20% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	

* 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	20% coinsurance	Limited to 60 visits per Calendar Year. *Pre-Service Review is required to prevent a penalty.*
	Rehabilitation services	Inpatient Rehabilitation services: 20% coinsurance Outpatient physical, occupational and speech therapy: Primary care: Primary care: $30 copayment per visit, then 0% coinsurance Specialist visit: $60 copayment per visit, then 0% coinsurance	Inpatient rehabilitation services is limited to 60 days per Calendar Year (combined with Skilled nursing care). Physical therapy and occupational therapy are limited to 20 combined visits per Calendar Year. Speech therapy is limited to 20 visits per Calendar Year. Cardiac rehabilitation is limited to 36 visits per Calendar Year. Pulmonary rehabilitation and cognitive therapy are limited to 20 combined visits per Calendar Year. Chiropractic care is limited to 20 visits per Calendar Year. *Pre-Service Review is required to prevent a penalty (except for initial evaluation for Physical, Occupational or Speech Therapy).*
	Habilitation services	See Rehabilitation services	See Rehabilitation services
	Skilled nursing care	20% coinsurance	Limited to 60 days per Calendar Year (combined with inpatient rehabilitation services. *Pre-Service Review is required to prevent a penalty.*
	Durable medical equipment	$5 copayment per item, then 0% coinsurance	*Pre-service review is required for purchases over $500 and all rentals to avoid a penalty.*
	Hospice services	$5 copayment per day, then 0% coinsurance	*Pre-Service Review for Inpatient is required to prevent a penalty.*
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered
	Children's glasses	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered

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

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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- Acupuncture
- Chiropractic care
- Hearing aids (age 0 – 18)
- Infertility treatment

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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 844-843-7150.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844-843-7150.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 844-843-7150.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 844-843-7150.

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	**$3,400**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,400
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,270**

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

The plan's overall deductible	**$3,400**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$3,400
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,820**

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

The plan's overall deductible	**$3,400**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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

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