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 844.713.1097. 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?	**Network Providers:** $0 per Plan Participant / $0 per Family Unit; **Non-Network Providers:** $2,000 per Plan Participant / $4,000 per Family Unit Each **JULY*** 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, prescription drug coverage, ambulance services, emergency room services, outpatient rehab services and the following Network Provider services: labs and x-rays, imaging services, office visits 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?	**Network Providers:** $5,000 per Plan Participant / $10,000 per Family Unit; **Non-Network Providers:** $5,000 per Plan Participant / $10,000 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?	Premiums , 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?	Yes. See www.imagine360.com or call 844.713.1097 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*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copayment per visit	$40 copayment per visit, no deductible applies	The office visit copayment applies once per visit and includes surgery, supplies, Labs and X-rays, Allergy Injections, Allergy Testing, Allergy Serum when performed on the same day, by the same provider, and regardless of an office visit charge.
	Specialist visit	$80 copayment per visit	$80 copayment per visit, no deductible applies	
	Preventive care/screening/ immunization	No Charge	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 for.
If you have a test	Diagnostic test Labs	$15 copayment per day	$15 copayment per day, no deductible applies	Limited to 1 copayment a day. If more than one copayment applies, the higher of the two will apply.
	X-rays	$50 copayment per day	$50 copayment per day, no deductible applies	
	Imaging (CT/PET scans, MRIs)	$150 copayment per day	$150 copayment per day, no deductible applies	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	$10 copayment per prescription (30-day supply) $20 copayment per prescription (90-day supply)		Deductible does not apply to prescription drug coverage. Retail Pharmacies is available up to a 30-day supply, mail order is available up to a 90-day supply.
	Preferred brand drugs	$40 copayment per prescription (30-day supply) $80 copayment per prescription (90-day supply)		
	Non-preferred brand drugs	$60 copayment per prescription (30-day supply) $120 copayment per prescription (90-day supply)		
	Specialty drugs	10% copayment ($300 max) per prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	25% coinsurance	None
	Physician/surgeon fees	25% coinsurance	25% coinsurance	None

* 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*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$400 copayment per visit, no deductible applies		Copayment waived if admitted
	Emergency medical transportation	25% coinsurance, no deductible applies		None
	Urgent care	$100 copayment per procedure	$100 copayment per procedure, no deductible applies	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	25% coinsurance	None
	Physician/surgeon fees	25% coinsurance	25% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance	25% coinsurance	None
	Office visits	$40 copayment per visit	$40 copayment per visit, no deductible applies	
	Inpatient services	25% coinsurance	25% coinsurance	None
If you are pregnant	Office visits	$40 copayment per visit	$40 copayment per visit, no deductible applies	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound).
	Childbirth/delivery professional services	25% coinsurance	25% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	25% coinsurance	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	25% coinsurance	Non-network providers are limited to 100 visits per Plan Year.
	Rehabilitation services	Inpatient: 25% coinsurance Outpatient: $40 copayment per visit	Inpatient: 25% coinsurance Outpatient: $40 copayment per visit, no deductible applies	Inpatient rehabilitation services are limited to 60 days per Plan Year. Physical Therapies, Speech Therapies, Pulmonary Therapies and Occupational Therapies are limited to 30 visits per therapy per Plan Year. Limits are waived in the case of an Autism Spectrum Disorder.
	Habilitation services	See Rehabilitation Service above		
	Skilled nursing care	25% coinsurance	25% coinsurance	Limited to 100 days per Plan Year
	Durable medical equipment	25% coinsurance	25% coinsurance	None
	Hospice services	25% coinsurance	25% coinsurance	None

* 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*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Glasses or Contact Lenses limited to $100 every 2 years (Limit does not apply to Dependents through age 18)
	Children's glasses	No Charge	No Charge	
	Children's dental check-up	Not Covered	Not Covered	None

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)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Routine eye care (Adult)

* 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: For group health coverage subject to ERISA, contact 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: For group health coverage subject to ERISA, 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 (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.

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**
■ **Specialist copayment**	**$80**
■ **Hospital (facility) coinsurance**	**25%**
■ **Other coinsurance**	**25%**

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	$0
Copayments	$600
Coinsurance	$2,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,460**

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

■ **The plan's overall deductible**	**$0**
■ **Specialist copayment**	**$80**
■ **Hospital (facility) coinsurance**	**25%**
■ **Other coinsurance**	**25%**

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	$0
Copayments	$900
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,120**

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

■ **The plan's overall deductible**	**$0**
■ **Specialist copayment**	**$80**
■ **Hospital (facility) coinsurance**	**25%**
■ **Other coinsurance**	**25%**

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	$800
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

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