**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 Imagine360 at 1-800-903-4360. 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 www.cciio.cms.gov or call 1-800-903-4360 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$3,000** person/**$6,000** family Level I & Level II MultiPlan PPO & Non-PPO | 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 services do not apply towards the deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a 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?** | **$6,550** person/**$13,100** family Level I & Level II MultiPlan PPO & Non-PPO | 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-billed charges; any noncompliance penalties; 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 page 2 for an explanation of Level I & Level II Providers. Visit www.multiplan.com/mpipracanc or call 1- 888-671-7427 for a list of participating Multiplan 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.
Level I Facilities include but are not limited to: Hospitals (Inpatient and Outpatient treatment); Inpatient Facilities (such as Rehabilitation Facilities, Skilled Nursing Facilities and Hospice); Inpatient and Outpatient Facilities of Mental Disorders, Chemical Dependency, Drug and Substance Abuse; Ambulatory Surgery Centers and Dialysis Clinics
Level II Physicians and all other Providers of service not defined as a Level I Provider.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Level I Facilities | Level II PPO Physicians | Level II Non-PPO Physicians | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | N/A | 30% coinsurance; deductible applies | | There is no charge for female office sterilization & all FDA approved contraceptive methods. $10 consult fee applies to UCM Digital Health consultations (excludes Behavioral Health). Non-PPO charges are based on Allowable Claims Limits. |
| | Specialist visit | N/A | 30% coinsurance; deductible applies | | |
| | Preventive care/screening/ immunization | No Charge | | | See your plan document for additional benefit information & limitations. Level I & Non-PPO charges are based on Allowable Claims Limits. 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) | 30% coinsurance; deductible applies | | | Level I & Non-PPO charges are based on Allowable Claims Limits. |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance; deductible applies | | | Level I & Non-PPO charges are based on Allowable Claims Limits. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at | Generic drugs | Walgreen's Advantage Network only: Deductible then 30% coinsurance Retail & Mail Order | | | Covers a 30-day supply for Retail/90-day supply for Mail Order/30-day supply for Specialty. Prescriptions cannot be filled at CVS Pharmacies. See your plan document for information about drugs that require prior authorization and drugs that |
| | Preferred brand drugs | Walgreen's Advantage Network only: Deductible then 30% coinsurance Retail & Mail Order | | | |
| | Non-preferred brand drugs | Walgreen's Advantage Network only: Deductible then 30% coinsurance Retail & Mail Order | | | |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Level I Facilities | Level II PPO Physicians | Level II Non-PPO Physicians | |
| www.express-scripts.com. | Specialty drugs | Walgreen's Advantage Network only: Deductible then 30% coinsurance | | | are excluded. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance; deductible applies | N/A | | UR notification required or 25% benefit reduction non-compliance penalty applies. Level I & Non-PPO charges are based on Allowable Claims Limits. |
| | Physician/surgeon fees | N/A | 30% coinsurance; deductible applies | | |
| **If you need immediate medical attention** | Emergency room care | 30% coinsurance; deductible applies | | | Contact UR for coordination of care. Level I & Non-PPO charges are based on Allowable Claims Limits. |
| | Emergency medical transportation | 30% coinsurance; deductible applies | | | Contact UR for coordination of care. Level I & Non-PPO charges are based on Allowable Claims Limits. |
| | Urgent care | 30% coinsurance; deductible applies | | | Level I & Non-PPO charges are based on Allowable Claims Limits. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% coinsurance; deductible applies | N/A | | UR notification required or 25% benefit reduction non-compliance penalty applies. Level I & Non-PPO charges are based on Allowable Claims Limits. |
| | Physician/surgeon fees | N/A | 30% coinsurance; deductible applies | | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 30% coinsurance; deductible applies | | | See '**If you visit a health care provider's office or clinic**' for the office visit benefit. UR notification required for Inpatient admissions and day treatment or 25% benefit reduction non-compliance penalty applies. Level I & Non-PPO charges are based on Allowable Claims Limits. |
| | Inpatient services | 30% coinsurance; deductible applies | | | |
| **If you are pregnant** | Office visits | N/A | 30% coinsurance; deductible applies | | Contact UR for coordination of prenatal care. Level I & Non-PPO charges are based on Allowable Claims Limits. |
| | Childbirth/delivery professional services | N/A | 30% coinsurance; deductible applies | | |
| | Childbirth/delivery facility services | 30% coinsurance; deductible applies | N/A | | |

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

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Level I Facilities | Level II PPO Physicians | Level II Non-PPO Physicians | |
| **If you need help recovering or have other special health needs** | Home health care | 30% coinsurance; deductible applies | | | Services are limited per calendar year to 120 visits for Home Health, 90 visits combined for Physical/Speech/ Occupational Therapy, 120 days for Skilled Nursing Facilities & 90 days for Rehabilitation Facilities. Treatment of developmental delays may not be covered. See your plan document for additional information. UR notification required for inpatient admission, Home Health, DME over $1,000 & Prosthetics over $1,000 or 25% benefit reduction non-compliance penalty applies. Level I & Non-PPO charges are based on Allowable Claims Limits. |
| | Rehabilitation services | 30% coinsurance; deductible applies | | | |
| | Habilitation services | 30% coinsurance; deductible applies | | | |
| | Skilled nursing care | 30% coinsurance; deductible applies | | | |
| | Durable medical equipment | 30% coinsurance; deductible applies | | | |
| | Hospice services | 30% coinsurance; deductible applies | | | |
| **If your child needs dental or eye care** | Children's eye exam | No Charge | | | Benefit applies to routine vision screenings for children. Non-PPO charges are based on Allowable Claims Limits. |
| | Children's glasses | Not Covered | | | Not Covered |
| | Children's dental check-up | Not Covered | | | Not Covered |

## 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.)**

- Cosmetic Surgery
- Dental Care (Adult)
- 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.)**

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Private Duty Nursing (Outpatient **only**)

[* For more information about limitations and exceptions, see the plan or policy document at mibenefits.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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services 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 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: 800-827-7223 or the Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

**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:**

Español: Para obtener asistencia en Español, llame al 800-827-7223

Tagalog: Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-827-7223

中文: 如果需要中文的帮助，请拨打这个号码 800-827-7223

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.***



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

## 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 MultiPlan deductible** **$3,000**
- **Specialist coinsurance** **30%**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

**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 | $3,000 |
| Copayments | $0 |
| Coinsurance | $2,870 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$5,930** |

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

- **The plan's overall MultiPlan deductible** **$3,000**
- **Specialist coinsurance** **30%**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

**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 | $3,000 |
| Copayments | $0 |
| Coinsurance | $730 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$3,750** |

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

- **The plan's overall MultiPlan deductible** **$3,000**
- **Specialist coinsurance** **30%**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

**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.