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, go to www.myperformancehlth.com or call 1-877-585-8480. 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. dol.gov/ebsa/healthreform.com or www.cciio.cms.gov

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For **Network providers** $5,000/individual or $10,000/family;for **Non-network providers** $10,000/individual or $20,000 family	Generally, you must pay all 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** services 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, but see chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For **Network providers** $6,550 individual / $13,100 family; for **Non-network providers** $20,000/individual or $40,000/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**, **balanced-billing** charges, 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.myfirsthealth.com for a list of participating 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 don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

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 visit to treat an injury or illness	Professional Fees: 20% After Deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	None
	Chiropractic Care	$20 copay/ Chiropractic, after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	20 visit limitations on Chiropractic Care.
	Specialist visit	Professional Fees: 20% After Deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	None
	Preventive care/screening/ immunization	0% coinsurance	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (blood work)	Facility: 20% deductible does not apply. Professional Fees: 20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	None
	Imaging (X-Ray, CT/PET scans, MRIs)	Facility: 20% coinsurance, deductible does not apply. Professional Fees: 20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction ($2,500 maximum).
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.magellanrx.com	Generic drugs	Discount Card	Not covered	Copays listed are for 0-30 day supply/prescription. 31-90 day supply; generic $45.00, brand name $90.00, Non-Preferred Brand $150.00 Copays apply to Retail and/or Mail Order.
	Preferred brand drugs	Discount Card	Not covered	
	Non-preferred brand drugs	Discount Card	Not covered	
	Specialty drugs	Excluded	Not covered	

[* For more information about limitations and exceptions, see the plan or policy document at www.myperformancehlth.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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Facility: 20% coinsurance, deductible does not apply	Deductible, 40% coinsurance subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction ($2,500 maximum).
	Physician/surgeon fees	Professional Fees: 20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	None
If you need immediate medical attention	Emergency room care	Facility: 20% coinsurance, deductible does not apply Professional Fees: 20% after deductible	Facility: 20% coinsurance, deductible does not apply Professional Fees: 20% after deductible	Out of network is subject to plan allowable fee.
	Emergency medical transportation	20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	None
	Urgent care	Professional Fees: 20% After Deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Facility: 20% coinsurance, deductible does not apply	Deductible, 40% coinsurance subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction ($2,500 maximum).
	Physician/surgeon fees	Professional Fees: 20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	None
If you need mental health, behavioral health and substance abuse services	Outpatient services	Professional Fees: 20% After Deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	None
	Inpatient services	Facility: 20% coinsurance, deductible does not apply. Professional Fees: 20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction ($2,500 maximum).
If you are pregnant	Office visits	Professional Fees: 20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	None

[* For more information about limitations and exceptions, see the plan or policy document at www.myperformancehlth.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)	
	Childbirth/delivery professional services	Professional Fees: 20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	None
	Childbirth/delivery facility services	Facility: 20% coinsurance, deductible does not apply	Deductible, 40% coinsurance subject to Plan's allowable fee	None
If you need help recovering or have other special health needs	Home health care	20% after deductible,	Deductible, 40% coinsurance subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction ($2,500 maximum).
	Rehabilitation services	20% after copayment,per visit	Deductible, 40% coinsurance subject to Plan's allowable fee	Limited to 20 visits per Calendar Year for physical, and occupational therapies each, 20 visits for Speech, 15 visits for Chiropractic. Subject to plan allowable
	Habilitation services	20% after copayment,per visit	Deductible, 40% coinsurance subject to Plan's allowable fee	Limited to 20 visits per Calendar Year, combined with the above therapies.
	Skilled nursing care	Facility: 20% of plan allowable, deductible does not apply Professional Fees: 20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	Limited to 60 days per Calendar Year. Failure to obtain precertification will result in a 50% benefit reduction ($2,500 maximum).
	Durable medical equipment	20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction ($2,500 maximum). Subject to plan allowable. (Limited to 12 month rental or purchase price, whichever is less)
	Hospice services	20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction ($2,500 maximum).
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

[* For more information about limitations and exceptions, see the plan or policy document at www.myperformancehlth.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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatments
- 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.)

- Chiropractic Care
- Durable medical equipment

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 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 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: Performance Health at 877-585-8480 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 [877-585-8480]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [877-585-8480]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码[877-585-8480]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [877-585-8480]

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

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	$5,000
Specialist *[cost sharing]*	80%
Hospital (facility) *[cost sharing]*	80%
Other *[cost sharing]*	0%

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	**$7,580**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$5,500**

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

The plan's overall deductible	$5,000
Specialist *[cost sharing]*	80%
Hospital (facility) *[cost sharing]*	80%
Other *[cost sharing]*	0%

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	**$1,000**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,000**

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

The plan's overall deductible	$5,000
Specialist *[cost sharing]*	80%
Hospital (facility) *[cost sharing]*	80%
Other *[cost sharing]*	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	**$3,500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$3,500**

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