

 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](http://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](http://www.dol.gov/ebsa/healthreform.com) or [www.cciio.cms.gov](http://www.cciio.cms.gov)

Important Questions	Answers	Why This Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p>For <a href="#">Network providers</a> \$7,350/individual or \$14,700/family; for <a href="#">Non-network providers</a> \$14,700/individual or \$29,400 family</p>	<p>Generally, you must pay all the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>No.</p>	<p>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.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p>For <a href="#">Network providers</a> \$7,350 individual / \$14,700 family; for <a href="#">Non-network providers</a> \$14,700/individual or \$29,400/family</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p><a href="#">Premiums</a>, <a href="#">balanced-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p>Will you pay less if you use a <a href="#">network provider</a>?</p>	<p>Yes. See <a href="http://www.myfirsthealth.com">www.myfirsthealth.com</a> for a list of participating providers</p>	<p>This <a href="#">plan</a> uses a provider <a href="#">network</a>. You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a>. You will pay the most if you use an <a href="#">out-of-network provider</a>, and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays (<a href="#">balance billing</a>) Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.</p>
<p>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</p>	<p>No. You don't need a referral to see a specialist.</p>	<p>You can see the <a href="#">specialist</a> you choose without permission from this plan.</p>

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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary visit to treat an injury or illness	0%, after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	None for Primary Care
	Chiropractic Care	0%, after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	20 visit limitations on Chiropractic Care.
	<a href="#">Specialist</a> visit	0%, after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	None
	<a href="#">Preventive care/screening/immunization</a>	0% coinsurance	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (blood work)	Facility and professional fees: 0%, after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	None
	Imaging (X-Ray, CT/PET scans, MRIs)	Facility: 0%, after deductible Professional Fees: 0%, after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum).
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.magellanrx.com">www.magellanrx.com</a>	Generic drugs	Discount Card	Not covered	<u>Copays</u> listed are for 0-30 day supply/prescription. 31-90 day supply; Discount Card
	Preferred brand drugs	Discount Card	Not covered	
	Non-preferred brand drugs	Discount Card	Not covered	
	<a href="#">Specialty drugs</a>	Excluded	Not covered	

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)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Facility: 0%, after deductible	Deductible, 50% <u>coinsurance</u> 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: 0%, after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	Facility: 0% after deductible  Professional Fees: 0%, after deductible	Facility: 0%, after deductible  Professional Fees: 0% after deductible	Out of network is subject to plan allowable fee.
	<a href="#">Emergency medical transportation</a>	0%, after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	None
	<a href="#">Urgent care</a>	0%, after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Facility: 0%, after deductible	Deductible, 50% <u>coinsurance</u> 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: 0%, after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	None
<b>If you need mental health, behavioral health and substance abuse services</b>	Outpatient services	0%, after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	None
	Inpatient services	Facility: 0%, after deductible  Professional Fees: 0%, after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum).
<b>If you are pregnant</b>	Office visits	Professional Fees: 0%, after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	None

[\* For more information about limitations and exceptions, see the plan or policy document at [www.myperformancehlth.com](http://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: 0%, after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	None
	Childbirth/delivery facility services	Facility: 0%, after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	None
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	0%, after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum).
	<a href="#">Rehabilitation services</a>	0%, after deductible,	Deductible, 50% <u>coinsurance</u> 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
	<a href="#">Habilitation services</a>	0%, after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	Limited to 20 visits per Calendar Year, combined with the above therapies.
	<a href="#">Skilled nursing care</a>	Facility: 0%, after deductible Professional Fees: 0%, after deductible	Deductible, 50% <u>coinsurance</u> 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).
	<a href="#">Durable medical equipment</a>	0%, after deductible	Deductible, 50% <u>coinsurance</u> 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)
	<a href="#">Hospice services</a>	0%, after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum).
<b>If your child needs dental or eye care</b>	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](http://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](http://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](http://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](http://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): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' [877-585-8480]

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](#) \$7,350
- [Specialist \[cost sharing\]](#) \$100
- [Hospital \(facility\) \[cost sharing\]](#) 100%
- [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*)

<b>Total Example Cost</b>	<b>\$7,580</b>
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,500
Copayments	\$100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$3,600</b>

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

- The [plan's](#) overall [deductible](#) \$7,350
- [Specialist \[cost sharing\]](#) \$100
- [Hospital \(facility\) \[cost sharing\]](#) 100%
- [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*)

<b>Total Example Cost</b>	<b>\$1,000</b>
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$100</b>

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

- The [plan's](#) overall [deductible](#) \$7,350
- [Specialist \[cost sharing\]](#) \$100
- [Hospital \(facility\) \[cost sharing\]](#) 20%
- [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*)

<b>Total Example Cost</b>	<b>\$3,500</b>
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In this example, Mia would pay:

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

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