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 copay/visit	Deductible, 40% coinsurance	None
	Specialist visit	$80 copay/visit	Deductible, 40% coinsurance	None
	Preventive care/screening/ immunization	Preventive Care: No charge Immunization: No charge	Deductible, 40% coinsurance	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)	20% coinsurance	Deductible, 40% coinsurance	Deductible applies to professional fees.
	Imaging (X-Ray, CT/PET scans, MRIs)	coinsurance	Deductible. 40% coinsurance	Failure to obtain precertification will result in a 50% benefit reduction ($500 maximum).
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.mycigna.com	Generic drugs	$15 copay/prescription	Not covered	Copays listed are for 0-30 day supply/prescription. 31-90 day supply are 2x's copays listed. Copays apply to Retail and/or Mail Order.
	Preferred brand drugs	$45 copay/prescription	Not covered	
	Non-preferred brand drugs	$85 copay/prescription	Not covered	
	Specialty Drugs	Excluded	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Deductible, 40% coinsurance	Failure to obtain precertification will result in a 50% benefit reduction ($500 maximum).
	Physician/surgeon fees	20% coinsurance	Deductible, 40% coinsurance	Deductible applies to professional fees.
If you need immediate medical attention	Emergency room care	$350 copay/visit, 20% coinsurance	$350 copay/visit, 20% coinsurance	Deductible applies to professional fees.

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)	
	Emergency medical transportation	20% after Deductible	Deductible, 40% coinsurance	None
	Urgent care	$80 copay/visit	Deductible, 40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Deductible, 40% coinsurance	Failure to obtain precertification will result in a 50% benefit reduction ($500 maximum).
	Physician/surgeon fees	Deductible, 20% coinsurance	Deductible, 40% coinsurance	None
If you need mental health, behavioral health and substance abuse services	Outpatient services	$40 copay/visit	Deductible. 40% coinsurance	None
	Inpatient services	20% coinsurance	Deductible, 40% coinsurance	Failure to obtain precertification will result in a 50% benefit reduction ($500 maximum). Deductible applies to professional fees.
If you are pregnant	Office visits	$40 copay/visit	Deductible, 40% coinsurance	None
	Childbirth/delivery professional services	20% after Deductible	Deductible, 40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	Deductible, 40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% after Deductible	Deductible, 40% coinsurance	Failure to obtain precertification will result in a 50% benefit reduction ($500 maximum).
	Rehabilitation services	$40 copay/visit	Deductible, 40% coinsurance	Limited to 20 visits per Calendar Year for physical and occupational therapies combined. Speech therapies is limited to 20 visits per Calendar Year.
	Habilitation services	$40 copay/visit	Deductible, 40% coinsurance	Limited to 20 visits per calendar Year.
	Skilled nursing care	20% coinsurance	Not Covered	Deductible applies to professional fees. Limited to 60 days per benefit period max.

[* 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)	
	Durable medical equipment	20% after Deductible	Deductible, 40% coinsurance	Failure to obtain precertification will result in a 50% benefit reduction ($500 maximum).
	Hospice services	20% after Deductible	Deductible, 40% coinsurance	Failure to obtain precertification will result in a 50% benefit reduction ($500 maximum).
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	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
- 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**

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

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]

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	$1,500
Specialist *[cost sharing]*	$50
Hospital (facility) *[cost sharing]*	0%
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	**$8,000**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,500**

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

The plan's overall deductible	$1,500
Specialist *[cost sharing]*	$50
Hospital (facility) *[cost sharing]*	0%
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	**$500**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$35
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$35**

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

The plan's overall deductible	$1,500
Specialist *[cost sharing]*	$50
Hospital (facility) *[cost sharing]*	0%
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	**$1,500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$350
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$350**

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