MED PERFORMANCE

Coverage for when you need it most.

CLASSIC MAJOR MEDICAL

MED PERFORMANCE

Plan	3500 Classic	
Telemedicine	Coverage through SwiftMD.com	
Network	CIGNA	
Lifetime Maximum	No Maximum	
Deductible & Max Out of Pocket Information	**In Network**	Out of Network
Individual Deductible / Max Out of Pocket	**$3,500 / $7,350**	$7,000 / $20,000
Family Deductible / Max Out of Pocket	**$7,000 / $14,700**	$14,000 / $29,400
Coinsurance Information (Deductible Must Be Met Before Coinsurance)	**In Network**	Out of Network
(Plan Responsibility / Member Responsibility)	**80% / 20%**	60% / 40%
Office Visits	**In Network**	Out of Network
Preventive Care	**$0 Copay**	40% Coinsurance
Primary Care Visit Copay	**$45 Copay**	40% Coinsurance
Specialist Care Visit Copay	**$90 Copay**	40% Coinsurance
Chiropractic Care Copay	**$20 Copay**	40% Coinsurance
Urgent Care Copay	**$90 Copay**	40% Coinsurance
Laboratory & Diagnostic Services	**In Network**	Out of Network
Facility	**20% Coinsurance**	40% Coinsurance
Professional Fees	**20% Coinsurance**	40% Coinsurance
Radiology Services	**In Network**	Out of Network
Facility (CT/PET/MRI/MRA/SPECT) & Professional Fees	**20% Coinsurance**	40% Coinsurance
Free Standing Facility (x-ray & lab only)	**20% Coinsurance**	40% Coinsurance
Facility & Professional Services	**In Network**	Out of Network
Emergency Room - Professional & Facility	**20% Coinsurance**	20% Coinsurance
Inpatient Hospital - Physician Fees & Facility	**20% Coinsurance**	40% Coinsurance
Outpatient Hospital - Physician Fees & Facility	**20% Coinsurance**	40% Coinsurance
Prescription Drug Benefit (Participating Pharmacy Only)	**In Network**	Out of Network
Preventive Generic	**$0 Copay**	N/A
Generic	**$15 Copay**	N/A
Preferred Brand	**$65 Copay**	N/A
Non-Preferred Brand	**$100 Copay**	N/A
Specialty	**50% Coinsurance**	N/A

Prescription Notes: Warning: If a Plan Participant request a Brand name drug when a Generic equivalent is available, then the Plan Participant must pay the Brand name drug copayment plus the difference in cost between the Brand name drug and the Generic drug. This expense will not apply to the maximum out-of-pocket amount as listed in the Schedule of Benefits

Plan Notes: Please review the plan schedule of benefits for a complete list of covered services If there are any discrepancies between this summary and the Plans Schedule of benefits, the Schedule of Benefits will govern.

MED PERFORMANCE

Plan	5000 Classic	
Telemedicine	Coverage through SwiftMD.com	
Network	CIGNA	
Lifetime Maximum	No Maximum	
Deductible & Max Out of Pocket Information	**In Network**	Out of Network
Individual Deductible / Max Out of Pocket	**$5,000 / $7,350**	$10,000/ $14,700
Family Deductible / Max Out of Pocket	**$10,000 / $14,700**	$20,000 / $29,400
Coinsurance Information (Deductible Must Be Met Before Coinsurance)	**In Network**	Out of Network
(Plan Responsibility / Member Responsibility)	**80% / 20%**	60% / 40%
Office Visits	**In Network**	Out of Network
Preventive Care	**$0 Copay**	60% Coinsurance
Primary Care Visit Copay	**$45 Copay**	60% Coinsurance
Specialist Care Visit Copay	**$90 Copay**	60% Coinsurance
Chiropractic Care Copay	**$20 Copay**	40% Coinsurance
Urgent Care Copay	**$90 Copay**	40% Coinsurance
Laboratory & Diagnostic Services	**In Network**	Out of Network
Facility	**20% Coinsurance**	40% Coinsurance
Professional Fees	**20% Coinsurance**	40% Coinsurance
Radiology Services	**In Network**	Out of Network
Facility (CT/PET/MRI/MRA/SPECT) & Professional Fees	**20% Coinsurance**	40% Coinsurance
Free Standing Facility (x-ray & lab only)	**20% Coinsurance**	40% Coinsurance
Facility & Professional Services	**In Network**	Out of Network
Emergency Room - Professional & Facility	**20% Coinsurance**	20% Coinsurance
Inpatient Hospital - Physician Fees & Facility	**20% Coinsurance**	40% Coinsurance
Outpatient Hospital - Physician Fees & Facility	**20% Coinsurance**	40% Coinsurance
Prescription Drug Benefit (Participating Pharmacy Only)	**In Network**	Out of Network
Preventive Generic	**$0 Copay**	N/A
Generic	**$15 Copay**	N/A
Preferred Brand	**$65 Copay**	N/A
Non-Preferred Brand	**$100 Copay**	N/A
Specialty	**50% Coinsurance**	N/A

Prescription Notes: Warning: If a Plan Participant request a Brand name drug when a Generic equivalent is available, then the Plan Participant must pay the Brand name drug copayment plus the difference in cost between the Brand name drug and the Generic drug. This expense will not apply to the maximum out-of-pocket amount as listed in the Schedule of Benefits

Plan Notes: Please review the plan schedule of benefits for a complete list of covered services If there are any discrepancies between this summary and the Plans Schedule of benefits, the Schedule of Benefits will govern.

MED PERFORMANCE

Plan	5000 HSA	
Telemedicine	Coverage through SwiftMD.com	
Network	CIGNA	
Lifetime Maximum	No Maximum	
Deductible & Max Out of Pocket Information	**In Network**	Out of Network
Individual Deductible / Max Out of Pocket	**$5,000 / $6,550**	$10,000 / $13,100
Family Deductible / Max Out of Pocket	**$10,000 / $13,100**	$20,000 / $26,200
Coinsurance Information (Deductible Must Be Met Before Coinsurance)	**In Network**	Out of Network
(Plan Responsibility / Member Responsibility)	**80% / 20%**	50% / 50%
Office Visits	**In Network**	Out of Network
Preventive Care	**$0 Copay**	50% Coinsurance
Primary Care Visit Copay	**20% Coinsurance**	50% Coinsurance
Specialist Care Visit Copay	**20% Coinsurance**	50% Coinsurance
Chiropractic Care Copay	**20% Coinsurance**	50% Coinsurance
Urgent Care Copay	**20% Coinsurance**	50% Coinsurance
Laboratory & Diagnostic Services	**In Network**	Out of Network
Facility	**20% Coinsurance**	50% Coinsurance
Professional Fees	**20% Coinsurance**	50% Coinsurance
Radiology Services	**In Network**	Out of Network
Facility (CT/PET/MRI/MRA/SPECT) & Professional Fees	**20% Coinsurance**	50% Coinsurance
Free Standing Facility (x-ray & lab only)	**20% Coinsurance**	50% Coinsurance
Facility & Professional Services	**In Network**	Out of Network
Emergency Room - Professional & Facility	**20% Coinsurance**	20% Coinsurance
Inpatient Hospital - Physician Fees & Facility	**20% Coinsurance**	50% Coinsurance
Outpatient Hospital - Physician Fees & Facility	**20% Coinsurance**	50% Coinsurance
Prescription Drug Benefit (Participating Pharmacy Only)	**In Network**	Out of Network
Preventive Generic	**$0 Copay**	N/A
Generic	**$15 Copay (After Deductible)**	N/A
Preferred Brand	**$65 Copay (After Deductible)**	N/A
Non-Preferred Brand	**$100 Copay (After Deductible)**	N/A
Specialty	**50% Coinsurance**	N/A

Prescription Notes: Warning: If a Plan Participant request a Brand name drug when a Generic equivalent is available, then the Plan Participant must pay the Brand name drug copayment plus the difference in cost between the Brand name drug and the Generic drug. This expense will not apply to the maximum out-of-pocket amount as listed in the Schedule of Benefits

Plan Notes: Please review the plan schedule of benefits for a complete list of covered services If there are any discrepancies between this summary and the Plans Schedule of benefits, the Schedule of Benefits will govern.

MED PERFORMANCE

Plan	7350 VALUE	
Telemedicine	Coverage through SwiftMD.com	
Network	CIGNA	
Lifetime Maximum	No Maximum	
Deductible & Max Out of Pocket Information	**In Network**	Out of Network
Individual Deductible / Max Out of Pocket	**$7,350 / $7,350**	$14,700 / $14,700
Family Deductible / Max Out of Pocket	**$14,700 / $14,700**	$29,400 / $29,400
Coinsurance Information (Deductible Must Be Met Before Coinsurance)	**In Network**	Out of Network
(Plan Responsibility / Member Responsibility)	**80% / 20%**	60% / 40%
Office Visits	**In Network**	Out of Network
Preventive Care	**$0 Copay**	40% Coinsurance
Primary Care Visit Copay	**$50 Copay**	40% Coinsurance
Specialist Care Visit Copay	**$100 Copay**	40% Coinsurance
Chiropractic Care Copay	**$20 Copay**	40% Coinsurance
Urgent Care Copay	**$100 Copay**	40% Coinsurance
Laboratory & Diagnostic Services	**In Network**	Out of Network
Facility	**20% Coinsurance**	40% Coinsurance
Professional Fees	**20% Coinsurance**	40% Coinsurance
Radiology Services	**In Network**	Out of Network
Facility (CT/PET/MRI/MRA/SPECT) & Professional Fees	**20% Coinsurance**	40% Coinsurance
Free Standing Facility (x-ray & lab only)	**20% Coinsurance**	40% Coinsurance
Facility & Professional Services	**In Network**	Out of Network
Emergency Room - Professional & Facility	**20% Coinsurance**	20% Coinsurance
Inpatient Hospital - Physician Fees & Facility	**20% Coinsurance**	40% Coinsurance
Outpatient Hospital - Physician Fees & Facility	**20% Coinsurance**	40% Coinsurance
Prescription Drug Benefit (Participating Pharmacy Only)	**In Network**	Out of Network
Preventive Generic	**$0 Copay**	N/A
Generic	**$15 Copay**	N/A
Preferred Brand	**$65 Copay**	N/A
Non-Preferred Brand	**$100 Copay**	N/A
Specialty	**50% Coinsurance**	N/A

Prescription Notes: Warning: If a Plan Participant request a Brand name drug when a Generic equivalent is available, then the Plan Participant must pay the Brand name drug copayment plus the difference in cost between the Brand name drug and the Generic drug. This expense will not apply to the maximum out-of-pocket amount as listed in the Schedule of Benefits

Plan Notes: Please review the plan schedule of benefits for a complete list of covered services If there are any discrepancies between this summary and the Plans Schedule of benefits, the Schedule of Benefits will govern.

MED PERFORMANCE

Age	Tier	3500 Classic	5000 Classic	5000 HSA	7350 Value
18 - 29	Employee	$731.44	$694.11	$644.53	$621.50
18 - 29	Employee & Spouse	$1,332.82	$1,259.45	$1,162.01	$1,116.74
18 - 29	Employee & Children	$1,222.64	$1,156.48	$1,068.61	$1,027.79
18 - 29	Employee & Family	$1,934.21	$1,824.80	$1,679.49	$1,611.99
30 - 39	Employee	$753.47	$714.70	$663.21	$639.29
30 - 39	Employee & Spouse	$1,376.89	$1,300.64	$1,199.37	$1,152.32
30 - 39	Employee & Children	$1,262.31	$1,193.55	$1,102.24	$1,059.81
30 - 39	Employee & Family	$2,000.32	$1,886.59	$1,735.53	$1,665.36
40 - 49	Employee	$780.96	$740.40	$686.51	$661.48
40 - 49	Employee & Spouse	$1,431.87	$1,352.02	$1,245.97	$1,196.70
40 - 49	Employee & Children	$1,311.79	$1,239.80	$1,144.18	$1,099.76
40 - 49	Employee & Family	$2,082.79	$1,963.66	$1,805.44	$1,731.94
50 - 59	Employee	$807.98	$765.65	$709.42	$683.30
50 - 59	Employee & Spouse	$1,485.91	$1,402.52	$1,291.78	$1,240.33
50 - 59	Employee & Children	$1,360.42	$1,285.25	$1,185.41	$1,139.02
50 - 59	Employee & Family	$2,163.84	$2,039.41	$1,874.15	$1,797.38
60 - 64	Employee	$837.42	$793.15	$734.37	$707.06
60 - 64	Employee & Spouse	$1,544.77	$1,457.54	$1,341.68	$1,287.85
60 - 64	Employee & Children	$1,413.40	$1,334.76	$1,230.32	$1,181.79
60 - 64	Employee & Family	$2,252.14	$2,121.94	$1,949.00	$1,868.66

This is an ERISA sponsored plan

Rates Above are for ACH.

GENERAL LIMITATIONS AND EXCLUSIONS

Some health care services are not covered by the Plan. Coverage is not available from the Plan for charges arising from care, supplies, treatment, and/or services:

Administrative Costs. That are solely for and/or applicable to administrative costs of completing claim forms or reports or for providing records wherever allowed by applicable law and/or regulation.

Complications of Non-Covered Services. That are required as a result of complications from a service not covered under the Plan, unless expressly stated otherwise.

Confined Persons. That are for services, supplies, and/or treatment of any Participant that were Incurred while confined and/or arising from confinement in a prison, jail or other penal institution with said confinement exceeding 2 consecutive hours.

Cosmetic Services, Supplies or Prescription Drugs - to improve, alter or enhance appearance for psychological or emotional reasons when there is no significant impairment, decrease in function, or change in physiology due to an injury, illness, or congenital anomaly. Cosmetic services, supplies or prescription drugs are eligible for coverage under the following circumstances only (a) to repair damage from an accident; (b) because of a covered illness; (c) because of a congenital anomaly causing a functional defect found at birth. The term “cosmetic services” includes those services which are described in IRS Code Section 213(d)(9).

Custodial Care. That do not restore health or are provided mainly as a rest cure or for maintenance care, unless specifically mentioned otherwise.

Excess. That exceed Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge as determined by The Third-Party Administrator, in accordance with the Plan terms as set forth by and within this document.

Experimental. That are Experimental or Investigational.

Foreign Travel. That are received outside of the United States unless in an emergency.

Gene Therapy. For gene therapies and associated services and supplies.

Government. That the Participant obtains, but which is paid, may be paid, is provided or could be provided at no cost to the Participant through any program or agency, in accordance with the laws or regulations of any government, or where care is provided at government expense, unless there is a legal obligation for the Participant to pay for such treatment or service in the absence of coverage. This includes care provided through the Military. This Exclusion does not apply when otherwise prohibited by law, including laws applicable to Medicaid and Medicare.

I**llegal Acts, Drugs, or Medication.** That are services, supplies, care or treatment to a Participant for Injury or Illness Incurred while the Participant was voluntarily taking or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician, even if the cause of the Illness or Injury is not related to the use of the controlled substance, drug, hallucinogen or narcotic. Expenses will be covered for Injured Participants other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Long Term Care. That refers to a range of services and supports needed by individuals who have a chronic illness or disability and are unable to perform basic activities of daily living (ADLs) without assistance. These services may include help with bathing, dressing, eating, toileting, transferring (e.g., moving from bed to chair), and continence.

Medical Necessity. That are not Medically Necessary and/or arise from services and/or supplies that are not Medically Necessary.

GENERAL LIMITATIONS AND EXCLUSIONS Continued

Some health care services are not covered by the Plan. Coverage is not available from the Plan for charges arising from care, supplies, treatment, and/or services:

Negligence. That are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, Institution, or Provider, as determined by The Third-Party Administrator, in its discretion, in light of applicable laws and evidence available to The Third-Party Administrator.

No Legal Obligation. That are for services provided to a Participant for which the Provider of a service does not and/or would not customarily render a direct charge, or charges Incurred for which the Participant or Plan has no legal obligation to pay, or for which no charges would be made in the absence of this coverage, including but not limited to charges for services not actually rendered, fees, care, supplies, or services for which a person, company or any other entity except the Participant or the Plan, may be liable for necessitating the fees, care, supplies, or services. This includes charges that would otherwise be waived or discounted based on factors such as a hospital's financial aid policy to the extent that this is consistent with Federal and State laws.

Not Specified As Covered. That are not specified as covered under any provision of this Plan or not performed by Providers who satisfy the requirements of the Provider definition defined in this Plan.

Occupational. Care and treatment of an Injury or Sickness that is occupational – that is, arises from work for wage or profit including self-employment. This includes claims in connection with any Injury or Illness arising out of or in the course of any employment for wage or profit; or related to professional or semi-professional athletics, including practice.

Subrogation, Reimbursement, and/or Third Party Responsibility. That are for an Illness or Injury not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions. This includes claims that are in connection with an automobile accident for which benefits payable hereunder are, or would be otherwise covered by, mandatory no-fault automobile insurance or any other similar type of personal injury insurance required by state or federal law, without regard to whether or not the Participant actually had such mandatory coverage. Benefits will be excluded to the maximum amount of first party medical coverage available under the applicable state law, regardless of a Participant's election of lesser coverage. This Exclusion does not apply if the Injured person is a passenger in a non-family owned vehicle or a pedestrian.

Unreasonable. That are required to treat Illness or Injuries arising from and due to error(s) caused at the time of treatment by the treating Provider including, but not limited to, a Physician or Hospital, wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This Exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of The Third-Party Administrator in its sole discretion, gave rise to the expense, which was caused directly or indirectly by the treating Provider, and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es).

Unreasonable due to excessive or hidden fees. That are based on charges that are not reasonable as required by the Employee Retirement Income Security Act of 1974(ERISA). Costs that exceed the Reasonable and Allowed Amount are unreasonable regardless of which enumerated reasons set forth in the description caused the Reasonable and Allowed Charge to be exceeded. Any undisclosed fees or fees that are lumped into other costs without distinguishing them are presumptively unreasonable.

War/Riot. That are Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, when the Participant is a member of the armed forces of any country, or during service by a Participant in the armed forces of any country, or voluntary participation in a riot. This Exclusion does not apply to any Participant who is not a member of the armed forces, and does not apply to victims of any act of war or aggression.

With respect to any Illness or Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Illness or Injury if the Illness or Injury results from being the victim of an act of domestic violence or a documented medical condition. To the extent consistent with applicable law, this exception will not require this Plan to provide particular benefits other than those provided under the terms of the Plan.

MEDICAL EXCLUSIONS

Obesity Treatment Charges for bariatric surgery, including but not limited to, gastric bypass, gastric sleeves, stapling and intestinal bypass, and lap band surgery, including reversals, related to both obesity and Class III obesity (if BMI is equal to or greater than 40.0 kg/m²). For non-Class III obesity, related to care and treatment of obesity, weight loss or dietary control. This Exclusion does not apply to obesity screening and counseling that are covered under the Preventive Care benefit. Treatment for complications caused by uncovered weight-loss surgery is not covered by the Plan. To determine if GLP-1s are covered, please call your pharmacy benefit manager, {pbmName}. Their number should be on the front of the member ID card.
Impotence A condition characterized by the consistent inability to achieve or maintain an erection sufficient for satisfactory sexual performance. Treatment may include prescription medications, devices, or other therapies. Coverage for services or supplies related to impotence is subject to the terms, limitations, and exclusions of the Plan, and may require medical necessity and prior authorization.

Hearing Aids Charges for hearing aids, which includes examinations for the prescription, fitting, and/or repair of hearing aids. Sterilization Reversal Surgical procedures intended to restore fertility after a voluntary sterilization, such as tubal ligation or vasectomy. Sterilization reversal procedures, including associated medical services and supplies, are not covered under the Plan unless specifically stated otherwise in the Plan documents.

Massage The manipulation of soft tissues of the body, including muscles and connective tissues, to relieve tension, improve circulation, or promote relaxation. Massage therapy may be provided for general wellness or as treatment for certain conditions. Coverage for massage, including therapeutic massage, is excluded under the Plan unless specifically prescribed as medically necessary and explicitly stated as a covered benefit in the Plan documents.

Orthopedic Shoes (Except Diabetics) Footwear designed to support or accommodate the structure and function of the foot, ankle, or leg. Unless specifically required for the treatment of diabetic foot conditions, expenses for orthopedic shoes (including fitting, modifications, and replacements) are not covered under the Plan.

Abortion The medical or surgical termination of a pregnancy. Coverage for abortion services is provided only as required under applicable federal and state law and is subject to the terms, limitations, and exclusions of the Plan.

Electroconvulsive Therapy A behavioral health treatment in which controlled electrical currents are passed through the brain under medical supervision to produce a brief seizure. Electroconvulsive therapy is not covered under the terms of the Plan.

Surrogacy Surrogacy refers to an arrangement in which another individual becomes pregnant and carries a child for an intended parent or parents. Expenses related to surrogacy — including, but not limited to, medical services for a surrogate, fertility treatments, legal fees, and compensation — are not covered under the Plan, unless specifically stated otherwise in the Plan documents.

Gender Affirming Care “Gender affirming care” refers to a range of medical, surgical, behavioral health, and supportive services that are intended to support an individual’s gender identity. Such care may include, but is not limited to, mental health counseling, hormone therapy, surgical procedures, and related follow-up care, when provided for the purpose of gender transition or gender identity support. Coverage for gender affirming care is provided only as required under applicable federal and state law and is subject to the terms, limitations, and exclusions of the Plan.

Biofeedback A therapeutic technique that uses electronic monitoring to help a person gain voluntary control over certain physiological functions, such as heart rate, muscle tension, or blood pressure, for the purpose of improving health or managing medical conditions. Biofeedback is considered by the Plan to be Investigational, and thus not covered.