




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, contact Clearwater Member Services at 877-405-2926. 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.healthcare.gov/sbc-glossary/ or call 877-405-2926 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible ? | \$0 Individual \$0 Family | See the Common Medical Events chart below for your costs for services this plan covers. |
| Are there services covered before you meet your deductible ? | Yes. All Covered Health Services are covered without a 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. |
| What is the out-of-pocket limit for this plan ? | \$8,700 Individual network provider, \$17,400 out-of-network provider. \$17,400 Family network provider, \$34,800 out-of-network provider. | 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-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.multiplan.com/webcenter/porta/ProviderSearch or https://pnoa-ppo.com/find-a-provider/ or call 877-405-2926 for a list of network 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.

| 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 | \$20/visit | \$50/visit | None. |
| | Specialist visit | \$50/visit | \$100/visit | None. |
| | Preventive care/screening/immunization | No charge | Not covered | Preventive services are only covered when received from a network provider . Out-of-network preventive care is not covered under this plan . 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) | X-Rays: \$50/test Labs: \$10/test | X-Rays: \$100/test Labs: \$25/test | None. |
| | Imaging (CT/PET scans, Ultrasounds, MRIs) | \$200/test | \$400/test | None. |
| If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.ehimrx.com . | Tier 1 - Generic | \$0/prescription | Not covered | Copayment covers up to a 30-day supply. Cost sharing for a 90-day supply is triple the copayment for a standard 30-day supply. |
| | Tier 2 - Preferred brand | \$20/prescription | Not covered | |
| | Tier 3 - Non-preferred brand | \$40/prescription | Not covered | |
| | Tier 4 - Specialty drugs | Not covered | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Not covered | Not covered | No coverage for outpatient surgery. |
| | Physician/surgeon fees | Not covered | 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) | |
| If you need immediate medical attention | Emergency room care | Not covered | Not covered | No coverage for emergency room care . |
| If you have a hospital stay | Facility fee (e.g., hospital room) | Not covered | Not covered | No coverage for hospital stays. |
| | Physician/surgeon fees | Not covered | Not covered | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient Services | Not covered | Not covered | No coverage for inpatient or outpatient mental health, behavioral health, or substance abuse services. |
| | Inpatient Services | Not covered | Not covered | |
| If you are pregnant | Office visits | No charge for preventive care visits. \$20/visit for primary care provider . \$50/visit for specialists . | Preventive care visits not covered. \$50/visit for primary care provider . \$100/visit for specialists . | Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound). Cost sharing does not apply to certain preventive services . Depending on the type of services, other cost sharing may apply. |
| | Childbirth / delivery professional services | Not covered | Not covered | No coverage for childbirth/delivery professional services. |
| | Childbirth / delivery facility services | Not covered | Not covered | No coverage for childbirth/delivery facility services. |
| If you need help recovering or have other special health needs | Home health care | Not covered | Not covered | No coverage for home health care . |
| | Rehabilitation services | Not covered | Not covered | No coverage for rehabilitation services . |
| | Habilitation services | Not covered | Not covered | No coverage for habilitation services . |
| | Skilled nursing care | Not covered | Not covered | No coverage for skilled nursing care . |
| | Durable medical equipment | Not covered | Not covered | No coverage for durable medical equipment . |
| | Hospice services | Not covered | Not covered | No coverage for hospice services . |

| 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 your child needs dental or eye care | Children's eye exam | No charge | Not covered | Preventive services are only covered when received from a network provider . Out-of-network preventive care is not covered under this plan . |
| | Children's glasses | Not covered | Not covered | No coverage for children's glasses. |
| | Children's dental check-up | No charge | Not covered | Preventive services are only covered when received from a network provider . Out-of-network preventive care is not covered under this plan . |

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 .) | | |
|---|---|---|
| <ul style="list-style-type: none"> • Abortion • Acupuncture • Anesthesia • Bariatric Surgery • Cancer Screenings & Treatment • Childbirth/delivery professional and facility services • Children's Glasses • Chiropractic Care • Cosmetic Surgery • Dental Care (Adult) | <ul style="list-style-type: none"> • Durable Medical Equipment • Emergency Room Services • Genetic Testing & Counseling • Habilitation Services • Hearing Aids • Home Health Care • Hospice Services • Hospital Admission or Facility • Infertility Treatment • Inpatient or Outpatient Surgery • Long-Term Care | <ul style="list-style-type: none"> • Mental Health, Behavioral Health, or Substance Abuse Services • Non-Emergency Care When Traveling Outside the U.S. • Pathology Services • Physical or Occupational Therapy • Rehabilitation Services • Routine Eye Care (Adult) • Skilled Nursing Care • Tubal Ligation • Vasectomy |

| Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your plan document.) |
|---|
| <ul style="list-style-type: none"> • None. |

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: Clearwater Member Services at 877-405-2926 or planhelp@boomyhealth.com; Texas Health Options at 1-800-252-3439 or www.texashealthoptions.com; or the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other options to continue coverage are 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 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: Clearwater Member Services at 877-405-2926 or planhelp@boomyhealth.com or the U.S. 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

[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? No

If your [plan](#) does not 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 1-877-405-2926.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-405-2926.

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 | \$0 |
| ■ Specialist copayment | \$50 |
| ■ Imaging copayment | \$200 |
| ■ Lab copayment | \$10 |

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 | \$0 |
| Copayments | \$600 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$8,500 |
| The total Peg would pay is | \$9,100 |

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---|-------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$50 |
| ■ Imaging copayment | \$200 |
| ■ Lab copayment | \$10 |

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 | \$0 |
| Copayments | \$300 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$800 |
| The total Joe would pay is | \$1,100 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|---|-------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$50 |
| ■ Imaging copayment | \$200 |
| ■ Lab copayment | \$10 |

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 | \$0 |
| Copayments | \$300 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$2,300 |
| The total Mia would pay is | \$2,600 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

* For more information about limitations and exceptions, see the [plan](#) or policy document at BoomyHealth.com.