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 855-893-8555. 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 855-893-8555 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$3,500** Single **$7,000** Family	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy of plan document to see when the deductible starts over (usually, but not always, January 1st). See the Common Medical Events chart below for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes, preventive care.	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?	**$5,500** single, **$11,000** 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?	Charges not authorized by a Utilization Review Program, 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 https://pnoa-ppo.com/find-a-provider/ or call 855-893-8555 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.

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

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% coinsurance		Office Visit Includes: diagnostic testing (except MRI, CT & PET scans), injections, allergy testing, allergy serum and allergy injections.
	Specialist visit	20% coinsurance		
	Preventive care/screening/ immunization	No charge		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)	0% coinsurance for labs. 20% coinsurance for x-ray.		See the Plan's Schedule of Benefits for PPO special notes.
	Imaging (CT/PET scans, Ultrasounds, MRIs)	20% coinsurance		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	$10/prescription retail; $20/prescription mail order	Not covered	Limited to: 30 day supply retail prescription 90 day supply mail order prescription
	Tier 2 - Preferred brand	$35/prescription retail; $70/prescription mail order	Not covered	
	Tier 3 - Non-preferred brand	$60/prescription retail; $120/prescription mail order	Not covered	
	Tier 4 - Specialty drugs	$50/prescription	Not covered	Limited to: 30 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance		None.
	Physician/surgeon fees	20% coinsurance		None.

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	20% coinsurance		None.
	Emergency Medical Transportation	20% coinsurance		Must be medically necessary.
	Urgent Care	20% coinsurance		Includes all related expenses.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance		Penalties for failure to obtain preauthorization for services subject to $500 per admission.
	Physician/surgeon fees	20% coinsurance		None.
If you need mental health, behavioral health, or substance abuse services	Outpatient Services	20% coinsurance		None.
	Inpatient Services	20% coinsurance		Penalties for failure to obtain preauthorization for services subject to $500 per admission.
If you are pregnant	Office visits	20% coinsurance		Dependent child maternity is not covered. Charges for office visits are considered under the global delivery fee. Cost sharing does not apply for preventive services. Depending on the type of services, other cost sharing may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth / delivery professional services	20% coinsurance		
	Childbirth / delivery facility services	20% coinsurance		
If you need help recovering or have other special health needs	Home health care	20% coinsurance		Limited to 40 professional visits per calendar year.
	Rehabilitation services	20% coinsurance		Must be medically necessary. Physical, Speech, and Occupational therapies are limited to 20 visits and/or $1,000 maximum per therapy, per calendar year. Speech therapy must be due to loss or impairment due to illness or injury, other than a functional disorder.

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)	
	Habilitation services	20% coinsurance		Limitations may apply based on the type of service rendered. Refer to your plan document.
	Skilled nursing care	20% coinsurance		Limited to 40 professional visits per calendar year.
	Durable medical equipment	20% coinsurance		None.
	Hospice services	20% coinsurance		Limited to 40 visits per calendar year.
If your child needs dental or eye care	Children's eye exam	20% coinsurance		None.
	Children's glasses	Not covered		None.
	Children's dental check-up	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
- Convalescent Care
- Cosmetic Surgery
- Dental Care (Adult)
- Experimental/Investigational Services
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Personal Comfort Items
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your plan document.)

- Chiropractic Care
- Private Duty Nursing

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: Boomy Member Services at 855-893-8555 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. 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: Boomy Member Services at 855-893-8555 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? Yes

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 1-855-893-8555.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-893-8555.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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

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	$3,000
Specialist copayment	20%
Hospital (facility) coinsurance	20%
Other Pharmacy 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	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$20
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$300
The total Peg would pay is	**$5,000**

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

The plan's overall deductible	$3,000
Specialist copayment	20%
Hospital (facility) coinsurance	20%
Other Pharmacy 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	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$800
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,700**

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

The plan's overall deductible	$3,000
Specialist copayment	20%
Hospital (facility) coinsurance	20%
Other Pharmacy 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	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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.