




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/](http://www.healthcare.gov/sbc-glossary/) or call 1-877-405-2926 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	Tier 1 - \$7,000 / individual or \$14,000 / family (in-network) Tier 2 - \$7,000 / Individual or \$14,000 / family (out of network)	Generally, you must pay all of the costs from <a href="#">providers</a> 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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes, \$250 Individual / \$500 Family RX Deductible	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <a href="#">network providers</a> \$8,500 individual / \$17,000 family; for <a href="#">out-of-network</a> providers \$14,000 individual / \$28,000 family	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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Penalties for non-compliance with plan provisions; <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="https://providerlocator.firstthealth.com/LocateProvider/SelectNetworkType">https://providerlocator.firstthealth.com/LocateProvider/SelectNetworkType</a> or call 1-877-405-2926 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's 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 <a href="#">provider's</a> 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.

Important Questions	Answers	Why This Matters:
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes.	This is a managed care plan. Any care beyond routine primary care office visits are subject to precertification and care coordination.

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies. If the deductible does not apply, neither does coinsurance.

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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$40 <a href="#">copay</a> /office visit for services up to \$500; <a href="#">deductible</a> applies to costs over \$500.	50% <a href="#">coinsurance</a>	
	<a href="#">Specialist</a> visit	\$60 <a href="#">copay</a> /visit for first 3 office visits for services up to \$500; <a href="#">deductible</a> applies to costs over \$500.; <a href="#">deductible</a> applies for office visits beyond the first 3  30% <a href="#">coinsurance</a> (outpatient hospital)	50% <a href="#">coinsurance</a>	This is managed care plan. <a href="#">Preauthorization</a> and coordination of care is required for access to benefits.
	<a href="#">Preventive care/screening/immunization</a>	No charge	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$60 <a href="#">copay</a> /test; for first 3 office visits for services up to \$500;	50% <a href="#">coinsurance</a>	This is managed care plan. <a href="#">Preauthorization</a> and coordination of care is required for access to benefits.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.boomyhealth.com](http://www.boomyhealth.com). For questions regarding prior authorization please call 877-405-2926.

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)	
		<a href="#">deductible</a> applies to costs over \$500.; <a href="#">deductible</a> applies for office visits beyond the first 3		
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a> (outpatient hospital)	50% <a href="#">coinsurance</a>	This is managed care plan. <a href="#">Preauthorization</a> and coordination of care is required for access to benefits.
<b>If you need drugs to treat your illness or condition</b> <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.ehimrx.com">www.ehimrx.com</a> or call 800-311-3446.	Generic drugs	\$0 <a href="#">copay</a> /prescription (30-day) \$0 <a href="#">copay</a> /prescription (90-day); RX <a href="#">deductible</a> applies	50% <a href="#">coinsurance</a>	Covers up to a 30-day supply (retail); 90-day supply (retail/mail order). Step therapy applies - includes the use of therapeutic alternatives.  RX Deductible applies to all tiers.
	Preferred brand drugs	\$55 <a href="#">copay</a> /prescription (30-day) \$110 <a href="#">copay</a> /prescription (90-day); <a href="#">deductible</a> applies	50% <a href="#">coinsurance</a>	
	Non-preferred brand drugs	\$100 <a href="#">copay</a> /prescription (30-day) \$200 <a href="#">copay</a> /prescription (90-day); <a href="#">deductible</a> applies	50% <a href="#">coinsurance</a>	
	<a href="#">Specialty drugs</a>	No Coverage	No Coverage	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$100/day <a href="#">copay</a>	50% <a href="#">coinsurance</a>	This is managed care plan. <a href="#">Preauthorization</a> and coordination of care is required for access to benefits.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
<b>If you need immediate</b>	<a href="#">Emergency room care</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	\$1,000 penalty for non-emergency visits. Notification is required within 48 hours or as

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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)	
medical attention				soon as reasonably possible, and coinsurance is waived if admitted as inpatient.
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	\$30 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply for the first 3 office visits, but does thereafter	50% <a href="#">coinsurance</a>	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	This is managed care plan. <a href="#">Preauthorization</a> and coordination of care is required for access to benefits.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <a href="#">copay</a> /office visit; <a href="#">deductible</a> does not apply for the first 3 office visits, but does thereafter (provider's office)	50% <a href="#">coinsurance</a>	This is managed care plan. <a href="#">Preauthorization</a> and coordination of care is required for access to benefits.
		30% <a href="#">coinsurance</a> (outpatient hospital)		
	Inpatient services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you are pregnant	Office visits	Initial visit: \$60 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply  Subsequent visits: No charge	50% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	

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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)	
	professional services Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	and coordination of care is required for access to benefits.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	This is managed care plan. <a href="#">Preauthorization</a> and coordination of care is required for access to benefits.  180 days/plan year limit.
	Chiropractic Services	\$60 <a href="#">copay</a> /visit; for first 3 office visits for services up to \$500; <a href="#">deductible</a> applies to costs over \$500.; <a href="#">deductible</a> applies for office visits beyond the first 3	50% <a href="#">coinsurance</a>	This is managed care plan. <a href="#">Preauthorization</a> and coordination of care is required for access to benefits.  Limited to 12 visits per calendar year.
	<a href="#">Rehabilitation services</a>	\$60 <a href="#">copay</a> /office visit; <a href="#">deductible</a> does not apply for the first 3 office visits, but does thereafter (provider's office)  30% <a href="#">coinsurance</a> (outpatient hospital)	50% <a href="#">coinsurance</a>	This is managed care plan. <a href="#">Preauthorization</a> and coordination of care is required for access to benefits.  Benefits are limited to 12 visits/year. Includes physical therapy, speech therapy, and occupational therapy.
	<a href="#">Habilitation services</a>	\$60 <a href="#">copay</a> /office visit; <a href="#">deductible</a> does not apply for the first 3 office visits, but does thereafter	50% <a href="#">coinsurance</a>	

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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)	
		(provider's office)  30% <a href="#">coinsurance</a> (outpatient hospital)		
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	This is managed care plan. <a href="#">Preauthorization</a> and coordination of care is required for access to benefits. Benefits are limited to 30 visits/calendar year.
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	This is managed care plan. <a href="#">Preauthorization</a> and coordination of care is required for access to benefits.
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	This is managed care plan. <a href="#">Preauthorization</a> and coordination of care is required for access to benefits. Benefits are limited to 30 days/calendar year.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$35 <a href="#">copay</a> /visit	Not covered	This is managed care plan. <a href="#">Preauthorization</a> and coordination of care is required for access to benefits Coverage limited to one exam/year.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric Surgery</li> <li>Cosmetic Surgery</li> <li>Dental Care (except for treatment to sound natural teeth required when due to injury.)</li> </ul>	<ul style="list-style-type: none"> <li>Hearing Aids,</li> <li>Infertility Treatment</li> <li>Long Term Care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private Duty Nursing</li> <li>Routine Eye Exam (Adult)</li> <li>Routine Foot Care</li> <li>Weight Loss Programs</li> </ul>

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**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- |  |  |   |
|--|--|---|
| <ul style="list-style-type: none"><li>• Chiropractic Care</li><li>• Dialysis</li></ul> | <ul style="list-style-type: none"><li>• Routing Hearing Exam</li></ul> | <ul style="list-style-type: none"><li>• Specialty Drugs</li></ul> |
|--|--|---|

**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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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 on how 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: [insert applicable contact information from instructions].

**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](#) 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 1-877-405-2926.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$7,000
■ <a href="#">Specialist copayment</a>	\$60
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$7,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$900

<i>What isn't covered</i>	
Limits or exclusions	\$2,700

<b>The total Peg would pay is</b>	<b>\$10,600</b>
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### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$7,000
■ <a href="#">Specialist copayment</a>	\$60
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a> *	\$1,200
<a href="#">Copayments</a>	\$1,000
<a href="#">Coinsurance</a>	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$20

<b>The total Joe would pay is</b>	<b>\$2,220</b>
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### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$7,000
■ <a href="#">Specialist copayment</a>	\$60
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a> *	\$2,500
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$0

<b>The total Mia would pay is</b>	<b>\$2,700</b>
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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