




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 ?	\$3,000 Single \$6,000 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 1 st). 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 , physician visits, specialist visits, urgent care , emergency room charges, and chiropractic 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 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 ?	\$6,000 single, \$12,000 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 ?	Penalties for failure to obtain pre-authorization for services, premiums , balance-billing charges, and prescription drug cost healthcare 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 .

 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	\$30 copay /visit; deductible does not apply		Office Visit Includes: diagnostic testing (except MRI, CT & PET scans), injections, allergy testing, allergy serum and allergy injections, office visits for behavioral health and/or substance abuse treatment and surgery.
	Specialist visit	\$60 copay /visit; deductible does not apply		
	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 Maximum out-of-pocket at a preferred provider – combined with medical.
	Tier 2 - Preferred brand	\$30/ prescription retail; \$60/ prescription mail order	Not covered	
	Tier 3 - Non-preferred brand	\$50/ prescription retail; \$100/ prescription mail order	Not covered	
	Tier 4 - Specialty drugs	\$50/ prescription	Not covered	Limited to: 30 day supply Maximum out-of-pocket at a preferred provider – combined with medical.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance		None.
	Physician/surgeon fees	20% coinsurance		See the Plan's Schedule of Benefits for PPO special notes.

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	\$200 copay /visit; deductible does not apply		Included all related expense (copayment is waived if admitted to hospital).
	Emergency Medical Transportation	20% coinsurance		Must be medically necessary .
	Urgent Care	\$100 copay /visit; deductible does not apply		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		See the Plan's Schedule of Benefits for PPO special notes.
If you need mental health, behavioral health, or substance abuse services	Outpatient Services	\$30 copay /visit; deductible does not apply Other outpatient - 20% coinsurance		Office Visit Includes: diagnostic testing (except MRI, CT & PET scans), injections, allergy testing, allergy serum and allergy injections, office visits for behavioral health and/or substance abuse treatment and surgery.
	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		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		Preauthorization is required for hospital stays greater than 2 days for a normal delivery and 4 days for a C-section.

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 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		Physical, Speech, and Occupational therapies are limited to 20 visits and \$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.
	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 | ● Hearing Aids | ● Personal Comfort Items |
| ● Bariatric Surgery | ● Infertility Treatment | ● Routine Eye Care (Adult) |
| ● Cosmetic Surgery | ● Long-Term Care | ● Routine Foot Care |
| ● Dental Care (Adult) | ● Non-Emergency Care When Traveling | ● Weight Loss Programs |
| ● Experimental/Investigational Services | Outside the U.S. | |

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.

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](#) \$60
- Hospital (facility) [coinsurance](#) 20%
- Other Pharmacy [copayment](#) \$10/\$20

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	\$280
The total Peg would pay is	\$5,200

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](#) \$60
- Hospital (facility) [coinsurance](#) 20%
- Other Pharmacy [copayment](#) \$10/\$20

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	\$0
Copayments	\$1,200
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$1,400

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 20%
- Other Emergency Room [copayment](#) \$200

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	\$1,400
Copayments	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,700

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.