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** Family 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/portal/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.

* 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/visit	Not covered	None.
	Specialist visit	$50/visit	Not covered	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)	Not covered	Not covered	No coverage for diagnostic tests.
	Imaging (CT/PET scans, Ultrasounds, MRIs)	Not covered	Not covered	No coverage for imaging.
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	

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

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.	Not covered.	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.)

- Abortion
- Acupuncture
- Anesthesia
- Bariatric Surgery
- Cancer Screenings & Treatment
- Childbirth/delivery professional and facility services
- Children's Glasses
- Chiropractic Care
- Cosmetic Surgery
- Dental Care (Adult)
- 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
- 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.)

- 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.*

* 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	$0
Primary care copayment	$20
Specialist copayment	$50
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	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$8,900
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
Primary care copayment	$20
Specialist copayment	$50
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	$3,900
The total Joe would pay is	**$4,200**

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

The plan's overall deductible	$0
Primary care copayment	$20
Specialist copayment	$50
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	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,500
The total Mia would pay is	**$2,700**

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.