**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 1-877-405-2926 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Tier 1 - $5,000 / individual or $15,000 / family (in-network)<br>Tier 2 - $5,000 / Individual or $15,000 / family (out of network) | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care and primary care services are covered before you meet your 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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | For network providers $5,000 individual / $15,000 family; for out-of-network providers $10,000 individual / $20,000 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 non-compliance with plan provisions; 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://providerlocator.firsthealth.com/LocateProvider/SelectNetworkType or call 1-877-405-2926 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?** | 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 provider's office or clinic** | Primary care visit to treat an injury or illness | 0% coinsurance; after Deductible | 50% coinsurance | $500 per visit benefit limit. |
| | Specialist visit | 0% coinsurance; after Deductible | 50% coinsurance | This is managed care plan. Preauthorization and coordination of care is required for access to benefits.<br><br>$500 per visit benefit limit. |
| | Preventive care/screening/ immunization | No charge | 50% coinsurance | 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; after Deductible | 50% coinsurance | This is managed care plan. Preauthorization and coordination of care is required for access to benefits.<br><br>$500 per visit benefit limit. |
| | Imaging (CT/PET scans, MRIs) | 0% coinsurance; after Deductible | 50% coinsurance | This is managed care plan. Preauthorization and coordination of care is required for access to benefits. |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.ehimrx.com **or call 800-311-3446.** | Generic drugs | 0% coinsurance; after Deductible | 50% coinsurance | Covers up to a 30-day supply (retail); 90-day supply (retail/mail order).<br><br>Step therapy applies - includes the use of therapeutic alternatives.<br>RX Deductible applies to all tiers.<br><br>*Members must call EHIM at 800-311-3446 to determine eligibility criteria and benefit |
| | Preferred brand drugs | 0% coinsurance; after Deductible | 50% coinsurance | |
| | Non-preferred brand drugs | 0% coinsurance; after Deductible | 50% coinsurance | |
| | Specialty drugs | *Call EHIM at 800-311-3446 to determine | No Coverage | |

* For more information about limitations and exceptions, see the plan or policy document at 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) | |
| | | benefit options. | | options. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 0% coinsurance; after Deductible | 50% coinsurance | This is managed care plan. Preauthorization and coordination of care is required for access to benefits. |
| | Physician/surgeon fees | 0% coinsurance; after Deductible | 50% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | 0% coinsurance; after Deductible | 30% coinsurance | $1,000 penalty for non-emergency visits. Notification is required within 48 hours or as soon as reasonably possible, and coinsurance is waived if admitted as inpatient. |
| | Emergency medical transportation | 0% coinsurance; after Deductible | 30% coinsurance | |
| | Urgent care | 0% coinsurance; after Deductible | 50% coinsurance | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 0% coinsurance; after Deductible | 50% coinsurance | This is managed care plan. Preauthorization and coordination of care is required for access to benefits. |
| | Physician/surgeon fees | 0% coinsurance; after Deductible | 50% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 0% coinsurance; after Deductible | 50% coinsurance | This is managed care plan. Preauthorization and coordination of care is required for access to benefits. |
| | Inpatient services | 0% coinsurance; after Deductible | 50% coinsurance | |
| **If you are pregnant** | Office visits | 0% coinsurance; after Deductible | 50% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).<br><br>This is managed care plan. Preauthorization and coordination of care is required for access to benefits. |
| | Childbirth/delivery professional services | 0% coinsurance; after Deductible | 50% coinsurance | |
| | Childbirth/delivery facility services | 0% coinsurance; after Deductible | 50% coinsurance | |

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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) | |
| **If you need help recovering or have other special health needs** | Home health care | 0% coinsurance; after Deductible | 50% coinsurance | This is managed care plan. Preauthorization and coordination of care is required for access to benefits.<br><br>180 days per calendar year limit. |
| | Chiropractic Services | 0% coinsurance; after Deductible | 50% coinsurance | This is managed care plan. Preauthorization and coordination of care is required for access to benefits.<br><br>$500 per visit benefit limit. Limited to 12 visits per calendar year. |
| | Rehabilitation services | 0% coinsurance; after Deductible | 50% coinsurance | This is managed care plan. Preauthorization and coordination of care is required for access to benefits.<br><br>Benefits are limited to 12 visits per calendar year. Includes physical therapy, speech therapy, and occupational therapy. |
| | Habilitation services | 0% coinsurance; after Deductible | 50% coinsurance | |
| | Skilled nursing care | 0% coinsurance; after Deductible | 50% coinsurance | This is managed care plan. Preauthorization and coordination of care is required for access to benefits.<br>Benefits are limited to 30 visits per calendar year. |
| | Durable medical equipment | 0% coinsurance; after Deductible | 50% coinsurance | This is managed care plan. Preauthorization and coordination of care is required for access to benefits. |
| | Hospice services | 0% coinsurance; after Deductible | 50% coinsurance | This is managed care plan. Preauthorization and coordination of care is required for access to benefits.<br>Benefits are limited to 30 days per calendar |

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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) | |
| | | | | year. |
| **If your child needs dental or eye care** | Children's eye exam | 0% coinsurance; after Deductible | Not covered | This is managed care plan. Preauthorization and coordination of care is required for access to benefits.<br>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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (except for treatment to sound natural teeth required when due to injury.)
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-Emergency Care when traveling outside the U.S.
- Private-Duty Nursing
- Routine Eye Exam (Adult)
- Routine Foot Care
- Weight Loss Programs

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

- Chiropractic Care
- Dialysis
- Routing Hearing Exam
- Specialty Drugs

**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 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 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,

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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.***

* For more information about limitations and exceptions, see the plan or policy document at www.boomyhealth.com. For questions regarding prior authorization please call 877-405-2926.

## 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 | $5,000 |
| Specialist copayment | $0 |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

**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 | $5,000 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **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 | $5,000 |
| Specialist copayment | $0 |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

**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* | $5,000 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$5,000** |

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

| | |
|---|---|
| The plan's overall deductible | $5,000 |
| Specialist copayment | $0 |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

**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* | $5,000 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,800** |

The plan would be responsible for the other costs of these EXAMPLE covered services.