




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 877-405-2926 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0 Individual \$0 Family	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. All Covered Health Services are covered without a <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> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$8,700 Individual network provider, \$17,400 out-of-network provider. \$17,400 Family network provider, \$34,800 out-of-network provider.	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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<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> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.multiplan.com/webcenter/portals/ProviderSearch">www.multiplan.com/webcenter/portals/ProviderSearch</a> or <a href="https://pnoa-ppo.com/find-a-provider/">https://pnoa-ppo.com/find-a-provider/</a> or call 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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20/visit	\$50/visit	None.
	<a href="#">Specialist</a> visit	\$50/visit	\$100/visit	None.
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	<a href="#">Preventive services</a> are only covered when received from a <a href="#">network provider</a> . <a href="#">Out-of-network preventive care</a> is not covered under this <a href="#">plan</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)	X-Rays: \$50/test Labs: \$10/test	X-Rays: \$100/test Labs: \$25/test	None.
	Imaging (CT/PET scans, Ultrasounds, MRIs)	\$200/test	\$400/test	None.
If you need drugs to treat your illness or condition. More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.ehimrx.com">www.ehimrx.com</a> .	Tier 1 - Generic	\$0/prescription	Not covered	<a href="#">Copayment</a> covers up to a 30-day supply. <a href="#">Cost sharing</a> for a 90-day supply is triple the <a href="#">copayment</a> 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 - <a href="#">Specialty drugs</a>	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)	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	Not covered	Not covered	No coverage for <a href="#">emergency room care</a> .
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Not covered	Not covered	No coverage for hospital stays.
	Physician/surgeon fees	Not covered	Not covered	
<b>If you need mental health, behavioral health, or substance abuse services</b>	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	
<b>If you are pregnant</b>	Office visits	No charge for <a href="#">preventive care</a> visits. \$20/visit for <a href="#">primary care provider</a> . \$50/visit for <a href="#">specialists</a> .	<a href="#">Preventive care</a> visits not covered. \$50/visit for <a href="#">primary care provider</a> . \$100/visit for <a href="#">specialists</a> .	Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound). <a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, other <a href="#">cost sharing</a> 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.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	Not covered	Not covered	No coverage for <a href="#">home health care</a> .
	<a href="#">Rehabilitation services</a>	Not covered	Not covered	No coverage for <a href="#">rehabilitation services</a> .
	<a href="#">Habilitation services</a>	Not covered	Not covered	No coverage for <a href="#">habilitation services</a> .
	<a href="#">Skilled nursing care</a>	Not covered	Not covered	No coverage for <a href="#">skilled nursing care</a> .
	<a href="#">Durable medical equipment</a>	Not covered	Not covered	No coverage for <a href="#">durable medical equipment</a> .
	<a href="#">Hospice services</a>	Not covered	Not covered	No coverage for <a href="#">hospice services</a> .

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	<a href="#">Preventive services</a> are only covered when received from a <a href="#">network provider</a> . <a href="#">Out-of-network preventive care</a> is not covered under this <a href="#">plan</a> .
	Children's glasses	Not covered	Not covered	No coverage for children's glasses.
	Children's dental check-up	No charge	Not covered	<a href="#">Preventive services</a> are only covered when received from a <a href="#">network provider</a> . <a href="#">Out-of-network preventive care</a> is not covered under this <a href="#">plan</a> .

#### 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>● Abortion</li> <li>● Acupuncture</li> <li>● Anesthesia</li> <li>● Bariatric Surgery</li> <li>● Cancer Screenings &amp; Treatment</li> <li>● Childbirth/delivery professional and facility services</li> <li>● Children's Glasses</li> <li>● Chiropractic Care</li> <li>● Cosmetic Surgery</li> <li>● Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>● Durable Medical Equipment</li> <li>● Emergency Room Services</li> <li>● Genetic Testing &amp; Counseling</li> <li>● Habilitation Services</li> <li>● Hearing Aids</li> <li>● Home Health Care</li> <li>● Hospice Services</li> <li>● Hospital Admission or Facility</li> <li>● Infertility Treatment</li> <li>● Inpatient or Outpatient Surgery</li> <li>● Long-Term Care</li> </ul>	<ul style="list-style-type: none"> <li>● Mental Health, Behavioral Health, or Substance Abuse Services</li> <li>● Non-Emergency Care When Traveling Outside the U.S.</li> <li>● Pathology Services</li> <li>● Physical or Occupational Therapy</li> <li>● Rehabilitation Services</li> <li>● Routine Eye Care (Adult)</li> <li>● Skilled Nursing Care</li> <li>● Tubal Ligation</li> <li>● Vasectomy</li> </ul>

Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your <a href="#">plan</a> document.)
<ul style="list-style-type: none"> <li>● None.</li> </ul>

\* For more information about limitations and exceptions, see the [plan](#) or policy document at BoomyHealth.com.

**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](mailto:planhelp@boomyhealth.com); Texas Health Options at 1-800-252-3439 or [www.texashealthoptions.com](http://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](http://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](http://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](mailto: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](http://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.*

## 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
- [Specialist copayment](#) \$50
- Imaging [copayment](#) \$200
- 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*)

<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>	\$0
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$8,500
<b>The total Peg would pay is</b>	<b>\$9,100</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$50
- Imaging [copayment](#) \$200
- 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*)

<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>	\$0
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$800
<b>The total Joe would pay is</b>	<b>\$1,100</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$50
- Imaging [copayment](#) \$200
- 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*)

<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>	\$0
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$2,300
<b>The total Mia would pay is</b>	<b>\$2,600</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.