



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 see www.lucenthealth.com/naa or call 1-800-411-3650. 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-877-236-0844 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$1,800 individual / \$3,600 family	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible ?	Yes. Preventive care and immunizations 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 ?	\$4,000 individual / \$8,000 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 ?	Premiums , balance-billing charges, penalties 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.primehealthpon.primehealthservices.com for a list of network providers . Network applies only to physicians and ancillary 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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance		Teladoc services available. See ID card.
	Specialist visit	0% coinsurance		None
	Preventive care/screening/immunization	No charge; deductible does not apply		You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance		None
	Imaging (CT/PET scans, MRIs)	0% coinsurance		Preauthorization is required. Failure to obtain preauthorization may result in claim denial.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	Retail (1-31 day supply): \$8 copay /prescription Retail (32-62 day supply): \$16 copay /prescription Retail (63-90 day supply): \$24 copay /prescription Mail order (1-90 day supply): 0% coinsurance /prescription	Out-of-network pharmacies are not covered	Deductible applies. Covers up to a 90-day supply for retail or mail order prescriptions. Prescription Drugs recommended by the HRSA or USPSTF will be covered at 100% as required by ACA.
	Preferred brand drugs	Retail (1-31 day supply): \$35 copay /prescription Retail (32-62 day supply): \$70 copay /prescription Retail (63-90 day supply): \$105 copay /prescription Mail order (1-90 day supply): 0% coinsurance /prescription		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
	Non-preferred brand drugs	Retail (1-31 day supply): \$50 copay /prescription Retail (32-62 day supply): \$100 copay /prescription Retail (63-90 day supply): \$150 copay /prescription Mail order (1-90 day supply): 0% coinsurance /prescription		Specialty drugs are limited to a 30-day supply.
	Specialty drugs	Follows Retail Pricing Above		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance		Preauthorization is required. Failure to obtain preauthorization may result in claim denial.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	0% coinsurance		None
	Emergency medical transportation	0% coinsurance		None
	Urgent care	0% coinsurance		None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance		Preauthorization is required. Failure to obtain preauthorization may result in claim denial.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance		None
	Inpatient services	0% coinsurance		Preauthorization is required. Failure to obtain preauthorization may result in claim denial.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	0% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization is required for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay. Failure to obtain preauthorization may result in claim denial.
	Childbirth/delivery professional services	0% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Limited to 120 visits per plan year combined with private duty nursing (physical, occupational, and speech therapies as well as home infusion is not included in this limit). Preauthorization is required. Failure to obtain preauthorization may result in claim denial.
	Rehabilitation services	0% coinsurance	Preauthorization is required for physical, occupational and speech therapies after the sixth visit each. Failure to obtain preauthorization may result in claim denial. Massage therapy is only covered when part of physical therapy treatment. Vision therapy is only covered when medical necessary.
	Habilitation services		
	Skilled nursing care	0% coinsurance	Preauthorization is required. Failure to obtain preauthorization may result in claim denial. Limited to 100 days per plan year.
	Durable medical equipment	0% coinsurance	None
	Hospice services	0% coinsurance	Preauthorization is required. Failure to obtain preauthorization may result in claim denial. Limited to participants with a life expectancy of 6 months or less. Family bereavement counseling is covered within 6 months of covered participant's death.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care	Children's eye exam	Not Covered	Routine screenings are covered as defined under the Patient Protection and Affordable Care Act of 2010.
	Children's glasses	Not Covered	None
	Children's dental check-up	Not Covered	Routine screenings are covered as defined under the Patient Protection and Affordable Care Act of 2010.

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 .)		
• Cosmetic surgery • Dental care (Adult) • Hearing aids	• Longer term care • Non-emergency care when traveling outside the U.S.	• Routine eye care • 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.)		
• Acupuncture • Bariatric surgery	• Chiropractic care • Infertility treatment	• 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: the plan at Richard J. Caron Health Plan c/o Lucent Health Solutions, LLC at PO Box 25207, Nashville, TN 37202 or call 1-800-411-3650. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and <https://www.cms.gov/cciio/Resources/consumer-assistance-grants>.

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](#).

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.lucenthhealth.com/naa

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-411-3650.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-411-3650.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-411-3650.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-800-411-3650 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-411-3650.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-411-3650.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-411-3650.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, â'gang 1-800-411-3650

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	\$1,800
■ Specialist coinsurance	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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,800
Copayments	\$40
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$1,840

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$1,800
■ Specialist coinsurance	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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,800
Copayments	\$600
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$00
The total Joe would pay is	\$2,400

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,800
■ Specialist coinsurance	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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,800
Copayments	\$10
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,810

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