



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, www.myLuminareHealth.com. 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 1-833-932-0854 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$300/individual or \$600/family per calendar year.	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 , hospice services and organ transplants 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 don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$500/individual or \$1,000/family per calendar year.	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 preauthorization for services, 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, for professional provider . See www.primehealthservices.com/pon search or call 1-877-277-4635 for a list of network providers .	This plan uses a professional provider 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).
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	10% coinsurance	None.
	Specialist visit	10% 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 needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	None.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.TrueRx.com or 1-866-921-4047.	Generic drugs	\$10 copay /prescription Retail & \$20 copay /prescription Mail Order	Copay applies to a 30-day supply Retail and or 31-90-day supply Mail-Order prescription. Copay does not apply to preventive drugs required by the Affordable Care Act. If you purchase a brand name drug when a generic drug is available, you must pay difference in cost. Specialty drugs : Rx Help Centers 1-866-478-9593 or www.rxhelpcenters.com .
	Preferred brand drugs	\$20 copay /prescription Retail & \$40 copay /prescription Mail Order	
	Non-preferred brand drugs	\$35 copay /prescription Retail & \$70 copay /prescription Mail Order	
	Specialty drugs	Not covered	

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Preauthorization is required for certain procedures.
	Physician/surgeon fees	10% coinsurance	None.
If you need immediate medical attention	Emergency room care	10% coinsurance	None.
	Emergency medical transportation	10% coinsurance	None.
	Urgent care	10% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Preauthorization is required.
	Physician/surgeon fees	10% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	None.
	Inpatient services	10% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	10% 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).
	Childbirth/delivery professional services	10% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	10% coinsurance	60 visits/calendar year. Limited to 3 intermittent visits per day; 1 visit equals a period of 4 hours or less. Preauthorization is required.
	Rehabilitation services	10% coinsurance	Includes physical therapy, speech therapy, and occupational therapy. Preauthorization is required for inpatient.
	Habilitation services	10% coinsurance	None
	Skilled nursing care	10% coinsurance	100 visits/calendar year. Preauthorization is required.
	Durable medical equipment	10% coinsurance	None.
	Hospice services	No charge (deductible does not apply)	Preauthorization is required for inpatient.
If your child needs dental or eye care	Children's eye exam	No charge (deductible does not apply)	Limited to 1 exam per 12 months.
	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 | • Infertility treatment | • Private-duty nursing |
| • Bariatric surgery | • Long-term care | • Routine foot care |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |
| • Dental care (Adult) | | |

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

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| • Chiropractic care | • Hearing aids (limited to one hearing aid per ear up to \$2,500 every 48 months for a covered person 21 years of age or younger) | • Routine eye care (Adult) |
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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 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: Contact Luminare Health Benefits, Inc. at 1-833-932-0854 or visit us at www.myLuminareHealth.com.

Additionally, a consumer assistance program can help you file your appeal. Contact the Superintendent of Insurance, Consumer Services Division, Ohio Department of Insurance, 2100 Stella Court, Columbus, OH 43215-1067 or call 1-800-686-1526.

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](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-833-932-0854.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-833-932-0854.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-932-0854.

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deutsch, ruf 1-833-932-0854 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-932-0854.

Samoa (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-833-932-0854.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-833-932-0854.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-833-932-0854.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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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	\$300
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$0
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$560

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$300
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$100
Coinsurance	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$480

Mia's Simple Fracture

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

■ The plan's overall deductible	\$300
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$10
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$500

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