Lucent Health
DATA DRIVEN + HUMAN FOCUSED

Frequently Asked Questions

1. **What is a value-based payment (VBP) plan?** Most health plans rely on a preferred provider organization (PPO) network. In this model, the PPO negotiates a contract with a facility and any claims incurred are paid based on that contract. In the VBP plan, facility claims are repriced based on a percentage of Medicare payment. This results in a lowered cost of care for everyone involved.

For procedures performed in a facility, the process begins during precertification. The plan requires you to gain preapproval for these procedures by calling the utilization review company at the number listed on your ID card. At this time, the plan may provide an estimated payment amount to the facility. Once the procedure has been performed, the plan pays based on that estimate as well as any other charges incurred during the procedure, just like a normal plan.

Because these claims are paid outside of a network contract, there is a chance the provider will dispute the payment amount and potentially balance bill you. In these cases, you should contact Narus Health at the number on your ID card. Narus Health will work with the Patient Advocacy Center (PAC) to educate the provider on the plan payment and negotiate, if necessary, to settle the balance bill. You may be required to sign some documents allowing the PAC to advocate for you while it is resolving the bill. The PAC will keep you informed on the status of the efforts until an agreement is reached. Please note, the PAC process takes on average 60 days to complete.

2. **Are my financial obligations capped at my out of pocket maximum? I will not be liable for the full "balancebill"?** That is correct. If you receive a bill from your provider that shows your responsibility is more than your explanation of benefits reflects, call Narus to alert them thatyou received a balance bill.

3. **What providers can I see? What facilities can I go to for treatment?** For physician and ancillary services, your plan utilizes a physician and ancillary only network called PHCS or Healthsmart (depending on your state of residence). However, your plan is open access for facilities, physicians and ancillary providers, which allows you to choose any service provider and facility. Your cost-share (applicable deductible, out-of-pocket and copay amounts)will not be affected by the provider's lack of participation the network. Further, you can choose to receive services at any hospital, skilled nursing facility, ambulatory surgery center or behavioral health facility where inpatient or outpatient services are provided.

4. **How do I find a PHCS physician or ancillary provider?** Contact PHCS to find a physician and confirm they are in the PHCS network.

   A. Online at www.multiplan.com/lucentphcs
   B. By phone at 877-559-7427

5. **How do I find a Healthsmart (TX, IN, and WA) physician or ancillary provider?** Contact Healthsmart to find a physician and confirm theyare in the Healthsmart network.

   A. Online at www.healthsmart.com
   B. By phone at 800-687-0500

6. **My physician is not currently in the PHCS/Healthsmart network.Will the medical plan continue to provide coveragefor visits to my physician?** Yes. This is an open access plan and all covered services for physician and ancillary providers, regardless of network participation, can be submitted for coverage under the medical plan. Your cost-share (applicable deductible, out-of-pocket and copays amounts) will not be affected by the provider's participation in the PHCS or Healthsmart network.

7. **What do I do if I go to a physician or ancillary service provider and they will not accept my insurance?** When possible, it is best to verify that your physician or ancillary service provider is in the network prior to your scheduled appointment. If there are any concerns with the physician or ancillary service provider accepting your insurance when you arrive for your appointment, contact Narus Health at the number on your ID card right away. Narus Health will verify your coverage and benefits, explain that all physicians are paid at the same benefit level as network providers on your plan, and seek a prompt resolution to the issue.

8. **What procedures/services require precertification?** All inpatient and outpatient procedures or surgeries performed in a facility (as defined above) require precertification and authorization. In addition, there are other services listed in the utilization review section of your plan document that will require precertification and authorization. These include but are not limited to: inpatient and outpatient behavioral health and chemical dependency; home healthcare and hospice care; physical, occupational and speech therapy; complex imagining (MRI, PET, CAT scan, etc.); and chemotherapy and radiation therapy. A copy of your plan document can be found on the mylucenthealth.com portal. Your physician should contact the precertification number listed on your ID card to have the procedure precertified. Narus Health will check for medical necessity and advise the provider if the requested service is authorized by the plan. PLEASE NOTE: Narus Health recommends the provider start the precertification process 5-7 days prior to the scheduled service date. Providers should call Lucent Health to confirm your eligibility and benefits at 877-214-2129.

9. **How do I know what procedures need to be precertified?** A list of procedures which require precertification are on the back of your ID card, along with the number for your provider to call to precertify them.

10. **During an emergency situation, where precertification cannot be performed, is there any risk of not being covered by health insurance?** No. Emergencies do not require precertification.

11. **What are my options for appeal if precertification denies my care at my chosen provider?** You may appeal a denial. However, since your plan is not limited to a network of providers, denials would not be due to a provider being "out of network." A denial would be based on a procedure not being covered by the plan benefits, not being medically necessary, etc.

12. **What do I do if my provider will not call or has not called the utilization review company to precertify a procedure?** Contact Narus Health at the number on your ID card. Narus Health will collect your name, member ID number, physician's name and contact information, type of procedure requested, and expected date of procedure. Your provider will be notified when the precertification is complete and authorization has been granted.

13. **What should I do if my physician has precertified my procedure but the facility where the procedure is scheduled says it will not accept my insurance and I will have to pay upfront if I do not want to cancel the procedure?** Contact Narus Health at the number on your ID card. Narus Health will collect your name, member ID number, facility name and contact information, physician's name and contact information, type of procedure, and date of procedure. Narus Health will coordinate with the plan on your behalf and let it know that the facility is not accepting the insurance. The plan will contact the facility and, if needed, begin pre-service negotiations. Narus Health will keep you informed on the status of the procedure.

14. **What is a balance bill?** If you receive a bill from a service provider that represents an amount owed by you that is greater than the amount represented on your Lucent Health Explanation of Benefits (EOB) as your "patient responsibility" for the same services, then you have received a balance bill.

15. **What should I do if I receive a balance bill?** Contact Narus Health at the number on your ID card. Narus Health will work with the plan to resolve the balance bill.

A. **Facility** - If the balance bill is from a facility, Narus Health will work with the Patient Advocacy Center (PAC) to educate the provider on the plan payment and negotiate, if necessary, to settle the balance bill. You may be required to sign documents allowing the PAC to represent you while it resolves the bill. The PAC will keep you informed on the status until an agreement is reached. Please note, the PAC process will take an average of 60 days to complete.

B. **Physician and Ancillary** - If the balance bill is from a physician or ancillary provider, Narus Health will educate the provider on the plan payment and work to settle the bill. Narus Health will keep you informed on the status during this process.

Please remember that you will be responsible for any amount represented as "patient responsibility" on the Lucent Health EOB. Make sure to pay your patient responsibility to the provider or contact the provider to set up a payment plan.

16. **How do I know what amount I'm supposed to pay to my providers and the facilities?** Contact Narus Health at the number on your ID card. Narus Health will assist you in reviewing any bills you receive from your providers and in understanding your Lucent Health Explanation of Benefits.

17. **None of my doctors are in the network. So you are saying they will all join if we call Narus Health?** No. Doctors have various reasons for not joining networks. If you want to nominate a doctor to the network, you will use the link on the PHCS or Healthsmart website.

If you visit a doctor out of the PHCS network, and there are issues related to that visit, or if you receive a balance bill, you would then call Narus Health.

18. **It seems that you stated that if I go to my physician and pay my copay, then the provider will send everything to Lucent Health and then I will receive my explanation of benefits (EOB). Is that right? Will I find outmy EOB after the service has already been provided?** Yes, asit is with every health insurance plan. The provider may giveyou an itemized statement the day you see them, or they may mail you an itemized statement. The claim must besubmitted and processed to generate an EOB.

19. What services are covered as "Preventive Care" and covered 100% of the allowable amount by the plan?

The preventive care benefits covered under the plan include:

A. Services with an A or B rating recommended by the United States Preventive Services Task Force (USPSTF).

B. Immunizations for routine use in children, adolescents and adults who have a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

D. With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of USPSTF).

E. All Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.

F. Routine physical exam and associated diagnostic tests and immunization.

G. Prostate specific antigen tests.

H. Mammograms are limited to one baseline mammogram beginning at age 35 and then annually for ages 40–74.

I. Shingles vaccination beginning at age 50.

For a complete listing on the services covered as "Preventive Care" by the plan, please refer to the Summary Plan Description (SPD).

20. **Do I need to call Narus Concierge to discuss my mammogram?** You may call Narus Concierge if you have questions about scheduling your mammogram. Your plan covers mammograms as follows: Age-appropriate preventive mammograms are covered at 100% with no cost share by the member. The plan (your employer) pays for them. Diagnostic mammograms are subject to the member's deductible or coinsurance. In either case, it is a good idea to call Narus Health to help locate an imaging center that is in-network or that does not issue a balance bill.

21. **Why did I receive three different explanations of benefits (EOB) for one procedure or surgery?** If you have a procedure that requires multiple physician and ancillary doctors to be in attendance to provide services, each provider will bill separately for their services. It is not uncommon for one procedure to result in claims from the facility, a surgeon (sometimes multiple surgeons), anesthesiologist (sometimes multiple anesthesiologists), and a laboratory. The plan will process and pay your claims as they are received, and you will receive an EOB for each claim submitted for payment.

22. **How do I submit a claim for reimbursement to Lucent Health if I had to pay for the services and the provider will not submit a claim?** Complete a Health Claim Reimbursement Form. Submit the completed form with a copy of a superbill from your provider and a receipt of your payment to email: mblackman@naa-lp.com or fax: 615-255-6654, attn: mailroom.

23. **What if I still have questions about the payment process, treatment plan and next steps?** Contact Narus Health at the number on your ID card. Narus Health will help you understand your plan and your benefits.

24. **Is there a way to communicate with the Narus Concierge team other than phone?** Yes, there are multiple ways to communicate with Narus Health. You may call, email or use the Narus Health app.

25. **What is the procedure with prescription drugs?** Prescription drugs are filled through Navitus, the pharmacy benefits manager. You go to a participating pharmacy or use mail order, just as with your current plan.

26. **Whom should I talk to about our prescription drugs?** If you have questions or concerns regarding your prescriptions, call Narus Health to discuss.

27. **Do I need to call Narus Health every time I use my plan or fill a prescription, unless it's an emergency?** No. You do not need to call anyone to get your prescriptions. You need to call Narus Health only if you have questions about your medications. For medical benefits, you need to call Narus Health only if you have questions, if you would like help finding a provider or understanding your benefits or EOBs, or if you receive a balance bill.

28. **Do I have a reason to be concerned about preexisting conditions?** No. Per the Affordable Care Act, there are no preexisting condition exclusions.

29. **May I view the full policy document?** Yes. Your employer will make a copy available for you. Check with your employer's human resources department for information on where to access it or to have a copy emailed to you or printed for you.