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 1-888-585-3309. 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 1-888-585-3309 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,000** individual / **$4,000** 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 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 services listed with a copay 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?	**$5,000** individual / **$10,000** 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?	No	N/A
Do you need a referral to see a specialist?	No	You can see the specialist you choose without permission from this plan.

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	$25 copay/visit; deductible does not apply		Includes Walk-In Clinics.
	Specialist visit	$45 copay/visit; deductible does not apply		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)	No charge; deductible does not apply		None
	Imaging (CT/PET scans, MRIs)	20% coinsurance		Preauthorization is required. Failure to obtain preauthorization will result in claims 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 and Mail Order; 1-34 day supply; $25 copay/prescription 35-90 day supply; $62.50 copay/prescription	Out-of-Network pharmacies are not covered	Deductible does not apply. Covers up to a 90-day supply (retail prescription); up to 90-day supply (mail order prescription). Prescription Drugs recommended by the HRSA or USPSTF will be covered at 100% as required by ACA.
	Preferred brand drugs	Retail and Mail Order; 1-34 day supply; $50 copay/prescription 35-90 day supply; $125 copay/prescription		

* For more information about limitations and exceptions, see the plan or policy document at www.lucenthealth.com/naa.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
	Non-preferred brand drugs	Retail and Mail Order 1-34 day supply; $75 copay/prescription Mail Order 35-90 day supply; $187.50 copay/prescription	Out-of-Network pharmacies are not covered	Specialty drugs are limited to a 30-day supply.
	Specialty drugs	Retail (1-34 day supply); $100 copay/prescription (34-90 day supply); $250 copay/prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge; deductible does not apply		Preauthorization is required. Failure to obtain preauthorization will result in claims denial.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	$250 copay/visit; deductible does not apply		Copay waived if admitted.
	Emergency medical transportation	20% coinsurance		None
	Urgent care	$100 copay/visit; deductible does not apply		None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge; deductible does not apply		Preauthorization is required. Failure to obtain preauthorization will result in claims denial.
	Physician/surgeon fees			

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit; deductible does not apply	None
	Inpatient services	No charge; deductible does not apply	Preauthorization is required. Failure to obtain preauthorization will result in claims denial.
If you are pregnant	Office visits	$25 copay/visit; deductible does not apply	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance or deductible 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 cesarean section deliveries requiring more than a 96 hour stay to avoid claims denial.
	Childbirth/delivery professional services	No charge; deductible does not apply	
	Childbirth/delivery facility services		
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Preauthorization is required. Failure to obtain preauthorization will result in claims denial. Limited to 60 visits per calendar year.
	Rehabilitation services	$45 copay/visit; deductible does not apply	Preauthorization is required for Physical, Occupational and Speech therapies after the first six visits each. Failure to obtain preauthorization will result in claims denial. Cardiac, Cognitive, and Pulmonary therapies limited to 36 visits each per calendar year. Occupational, Physical and Speech therapies limited to 60 visits combined per calendar year. Massage and Vision therapies are not covered.
	Habilitation services		
	Skilled nursing care	20% coinsurance	Preauthorization is required. Failure to obtain preauthorization will result in claims denial. Limited 60 days per calendar year.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
	Durable medical equipment	20% coinsurance	None
	Hospice services	No charge; deductible does not apply	Preauthorization is required. Failure to obtain preauthorization will result in claims denial. Limited to those participants with a life expectancy of six months or less. Family Bereavement Counseling covered within six months of covered person's death.
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)
- Long Term Care
- Non-Emergency care when traveling outside the U.S.
- Routine Eye Care
- Routine eye care (Adult)
- Private Duty Nursing
- 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
- Hearing Aids
- Infertility treatment

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 HeartShare Human Services of New York dba Heart Share Health Plan c/o Lucent Health Solutions, LLC at www.lucenthealth.com/naa or call 1-888-585-3309. 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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-585-3309.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-888-585-3309.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-585-3309.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-888-585-3309 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-585-3309.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-888-585-3309.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-888-585-3309.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-888-585-3309.

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	**$2,000**
Specialist *[cost sharing]*	**$45**
Hospital (facility) copay	**$0**
Other coinsurance	**20%**

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	$300
Copayments	$0
Coinsurance	$10
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$370**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$2,000**
Specialist *[cost sharing]*	**$45**
Hospital (facility) copay	**$0**
Other coinsurance	**20%**

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	$800
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,920**

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

The plan's overall deductible	**$2,000**
Specialist *[cost sharing]*	**$45**
Hospital (facility) copay	**$0**
Other coinsurance	**20%**

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	$1,300
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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