




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/cypress](http://www.lucenthealth.com/cypress) or call 1-877-236-0844. 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 <a href="#">deductible</a> ?	\$5,000 individual / \$10,000 family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of deductible expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. The following services: <ul style="list-style-type: none"> <li>• <a href="#">Preventive care</a></li> <li>• Primary Care / <a href="#">Specialist</a> visits</li> <li>• <a href="#">Diagnostic test</a> (x-rays only)</li> <li>• Imaging (CT/PET/MRI)</li> <li>• <a href="#">Urgent care</a></li> </ul>	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> ?	\$6,350 individual / \$12,700 family	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, penalties 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> ?	Not applicable.	This plan does not use a provider network. You can receive covered services from any provider.
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> .


**Questions:** Call 1-877-236-0844 or visit us at [www.lucenthealth.com/cypress](http://www.lucenthealth.com/cypress). If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at the above link or call 1-877-236-0844 to request a copy.

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	Preferred PCP: <a href="http://www.myemployersolutions.com">www.myemployersolutions.com</a> \$10 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply  All others: \$30 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply	<a href="#">Copay</a> applies per visit for <a href="#">providers</a> no matter what services are rendered.
	<a href="#">Specialist</a> visit	\$60 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply  Chiropractic Care: 20% <a href="#">coinsurance</a>	<a href="#">Copay</a> applies per visit for <a href="#">providers</a> no matter what services are rendered. Chiropractic care is limited to 20 visits per plan year.
	<a href="#">Preventive care/screening/immunization</a>	No charge; <a href="#">deductible</a> does not apply	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need 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)	Lab: \$0 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply X-ray: \$75 <a href="#">copay</a> per x-ray; <a href="#">deductible</a> does not apply	None
	Imaging (CT/PET scans, MRIs)	\$400 <a href="#">copay</a> per scan; <a href="#">deductible</a> does not apply	<a href="#">Preauthorization</a> is required. If you don't receive <a href="#">preauthorization</a> , benefits will be denied.
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.magellanrx.com">www.magellanrx.com</a> or call 1-800-424-5876.	Generic drugs (Tier 1)	Retail and Mail Order: \$10 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply	Non-Participating Pharmacies not covered.  Covers up to a 30-day supply (retail prescription); 31-90-day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	Retail and Mail Order: \$30 <a href="#">copay</a> ; after <a href="#">deductible</a>	
	Non-preferred brand drugs (Tier 3)	Retail and Mail Order: \$50 <a href="#">copay</a> ; after <a href="#">deductible</a>	
	<a href="#">Specialty drugs</a> (Tier 4)	Retail and Mail Order: \$500 <a href="#">copay</a> ; after <a href="#">deductible</a>	Specialty drugs limited to a 30-day supply

 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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for Outpatient stays over 12 hours. If you don't receive <a href="#">preauthorization</a> , benefits will be denied.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	<a href="#">Deductible</a> applies.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	<a href="#">Deductible</a> applies.
	<a href="#">Urgent care</a>	\$75 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't receive <a href="#">preauthorization</a> , benefits will be denied.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply	None
	Inpatient services	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't receive <a href="#">preauthorization</a> , benefits will be denied.
If you are pregnant	Office visits	\$30 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply	<a href="#">Copay</a> applies to the initial visit only. <a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">copays</a> , <a href="#">deductible</a> and <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <a href="#">Preauthorization</a> is required for continuing hospital stays over 48 hours following vaginal delivery or 96 hours following a Cesarean section.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't receive <a href="#">preauthorization</a> , benefits will be denied. Limited to 60 visits per plan year.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required after six (6) visits. If you don't receive <a href="#">preauthorization</a> , benefits will be denied. Occupational, speech and physical therapies are limited to 30 combined visits per plan year for rehabilitation/habilitation.

 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
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't receive <a href="#">preauthorization</a> , benefits will be denied. Covers the diagnosis, testing and treatment of autism, ADD or ADHD.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't receive <a href="#">preauthorization</a> , benefits will be denied. Limited to 60 days per plan year.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't receive <a href="#">preauthorization</a> , benefits will be denied.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't receive <a href="#">preauthorization</a> , benefits will be denied.
If your child needs dental or eye care	Children's eye exam	\$30 <a href="#">copay</a> or \$60 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply	Limited to one exam per 24-month period. Routine screenings 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 covered as defined under the Patient Protection and Affordable Care Act of 2010.

#### 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>Acupuncture</li> <li>Bariatric Surgery</li> <li>Cosmetic Surgery</li> <li>Dental Care</li> </ul>	<ul style="list-style-type: none"> <li>Hearing Aids</li> <li>Infertility Treatment</li> <li>Long Term Care</li> <li>Non-emergency care when traveling outside U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private Duty Nursing</li> <li>Routine eye care (Adult)</li> <li>Routine Foot Care</li> <li>Weight Loss Programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Chiropractic Care (20 visits per plan year)</li> </ul>		

**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](http://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](http://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](http://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 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 1-877-236-0844. 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](http://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](http://www.dol.gov/ebsa/healthreform) and <http://www.cms.gov/CCIO/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 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 1-877-236-0844

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-236-0844

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-236-0844

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-236-0844

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*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,350
■ <a href="#">Specialist copayment</a>	\$60
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$5,000
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$700
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,960</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,350
■ <a href="#">Specialist copayment</a>	\$60
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$800
<a href="#">Copayments</a>	\$900
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,720</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,350
■ <a href="#">Specialist copayment</a>	\$60
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

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