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 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?	Network providers **$2,500** individual / **$5,000** family Out-of-network providers **Not Covered**	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 with a copay may be 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?	Network providers **$5,000** individual / **$10,000** family Out-of-network providers **Not Covered**	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.mycigna.com for a list of participating 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay/office visit; deductible does not apply	Not Covered	Teladoc services available. See ID Card.
	Specialist visit	$80 copay/office visit; deductible does not apply	Not Covered	None
	Preventive care/screening/ immunization	No charge; deductible does not apply	Not Covered	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)	20% coinsurance; deductible does not apply	Not Covered	Independent Labs included
	Imaging (CT/PET scans, MRIs)	$400 copay/visit; deductible does not apply	Not Covered	Preauthorization is required. Failure to obtain preauthorization could result in a $250 penalty.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.ProActRx.com** or call 1-877-635-9545.	Generic drugs	30-Day supply: $15 copay/prescription Retail and Mail Order 60-Day supply: $30 copay/prescription 90-Day supply: $37.50 copay/prescription	Not Covered	Deductible does not apply. Covers up to a 90-day supply (retail and mail order prescription). Prescription Drugs recommended by the HRSA or USPSTF will be covered at 100% as required by ACA.
	Preferred brand drugs	30-Day supply: $40 copay/prescription Retail and Mail Order 60-Day supply: $80 copay/prescription 90-Day supply: $100 copay/prescription		

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Non-preferred brand drugs	30-Day supply: $80 copay/prescription Retail and Mail Order 60-Day supply: $160 copay/prescription 90-Day supply: $200 copay/prescription	Not Covered	
	Specialty drugs	Mail Order Only: 20% coinsurance up to a $300 maximum		Specialty drugs are limited to a 30-day supply and require preauthorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	Preauthorization is required. Failure to obtain preauthorization could result in a $250 penalty.
	Physician/surgeon fees	20% coinsurance	Not Covered	
If you need immediate medical attention	Emergency room care	$500 copay/visit, then 20% coinsurance; deductible does not apply		Copay waived if admitted.
	Emergency medical transportation	20% coinsurance		Network deductible applies to Out-of-network services.
	Urgent care	$65 copay/visit; deductible does not apply	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	Preauthorization is required. Failure to obtain preauthorization could result in a $250 penalty.
	Physician/surgeon fees	20% coinsurance	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Physician: $40 copay/visit; deductible does not apply Non-Physician: 20% coinsurance; deductible does not apply	Not Covered	None
	Inpatient services	20% coinsurance	Not Covered	Preauthorization is required. Failure to obtain preauthorization could result in a $250 penalty.
If you are pregnant	Office visits	$40 copay/office visit; deductible does not apply	Not Covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, cost-sharing 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 to avoid a $250 penalty.
	Childbirth/delivery professional services	20% coinsurance	Not Covered	
	Childbirth/delivery facility services	20% coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	Preauthorization is required. Failure to obtain preauthorization could result in a $250 penalty. Limited to 120 visits per Calendar Year. Private Duty Nursing and therapy services included in limit.
	Rehabilitation services	Aural, Occupational, Physical and Speech Therapy: $80 copay/visit; deductible does not apply All Other: 20% coinsurance	Not Covered	Preauthorization is required after ther first six visits. Failure to obtain preauthorization could result in a $250 penalty. Aural, Occupational and Speech Therapy limited to 40 visits per Calendar Year. Limits do not apply to Autism.
	Habilitation services			

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Skilled nursing care	20% coinsurance	Not Covered	Preauthorization is required. Failure to obtain preauthorization could result in a $250 penalty. Limited to 100 days per Calendar Year.
	Durable medical equipment	20% coinsurance	Not Covered	None
	Hospice services	20% coinsurance	Not Covered	Preauthorization is required. Failure to obtain preauthorization could result in a $250 penalty. Coverage begins when life expectancy is six months or less.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Routine screenings covered as defined under the Patient Protection and Affordable Care Act of 2010.
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Routine screenings 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.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (adult)
- Infertility Treatment (except when diagnosing or treating an underlying condition)
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (adult)
- 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.)

- Abortion (limited to one elective procedure per lifetime)
- Chiropractic Care (limited to 20 visits per Calendar Year)
- Hearing Aids (limited to one per ear every three years, $3,000 maximum per ear every three years)
- Private Duty Nursing (Home Health only)

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 Summit Community Care Clinic Health Plan c/o Lucent Health Solutions, LLC at PO Box 7020 Appleton, WI 54912-7020 or call 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, 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 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 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.

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

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-585-3309.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 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	**$2,500**
Specialist copayment	**$80**
Hospital (facility) coinsurance	**20%**
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	$2,500
Copayments	$400
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,860**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	**$2,500**
Specialist copay	**$80**
Hospital (facility) coinsurance	**20%**
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	$20
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,940**

Mia's Simple Fracture

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

The plan's overall deductible	**$2,500**
Specialist copayment	**$80**
Hospital (facility) coinsurance	**20%**
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	$1,200
Copayments	$1,000
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,280**

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