
 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 \$6,000 individual / \$12,000 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 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 \$6,000 individual / \$12,000 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 | 0% coinsurance | Not Covered | Teladoc services available. See ID Card. |
| | Specialist visit | 0% coinsurance | 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) | 0% coinsurance | Not Covered | Independent Labs included |
| | Imaging (CT/PET scans, MRIs) | 0% coinsurance | 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 | Retail and Mail Order: 0% coinsurance | Not Covered | Deductible applies 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. Specialty drugs are limited to a 30-day supply and require preauthorization . |
| | Preferred brand drugs | Retail and Mail Order: 0% coinsurance | | |
| | Non-preferred brand drugs | Retail and Mail Order: 0% coinsurance | | |
| | Specialty drugs | Mail Order Only: 0% coinsurance | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 0% coinsurance | Not Covered | Preauthorization is required. Failure to obtain preauthorization could result in a \$250 penalty. |
| | Physician/surgeon fees | 0% coinsurance | Not Covered | |

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.lucenthhealth.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) | |
| If you need immediate medical attention | Emergency room care | 0% coinsurance | | Network deductible applies to Out-of-network services. |
| | Emergency medical transportation | 0% coinsurance | | Network deductible applies to Out-of-network services. |
| | Urgent care | 0% coinsurance | Not Covered | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 0% coinsurance | Not Covered | Preauthorization is required. Failure to obtain preauthorization could result in a \$250 penalty. |
| | Physician/surgeon fees | 0% coinsurance | Not Covered | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 0% coinsurance | Not Covered | None |
| | Inpatient services | 0% coinsurance | Not Covered | Preauthorization is required. Failure to obtain preauthorization could result in a \$250 penalty. |
| If you are pregnant | Office visits | 0% coinsurance | 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 | 0% coinsurance | Not Covered | |
| | Childbirth/delivery facility services | 0% coinsurance | Not Covered | |
| If you need help recovering or have other special health needs | Home health care | 0% 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. |

* 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) | |
| | Rehabilitation services | 0% coinsurance | Not Covered | Preauthorization is required after their 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 | | | |
| | Skilled nursing care | 0% coinsurance | Not Covered | |
| | Durable medical equipment | 0% coinsurance | Not Covered | |
| | Hospice services | 0% coinsurance | Not Covered | |
| 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 .) | | |
|---|--|---|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric Surgery • Cosmetic Surgery • Dental Care (adult) | <ul style="list-style-type: none"> • Infertility Treatment (except when diagnosing or treating an underlying condition) • Long Term Care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Routine Eye Care (adult) • Routine Foot Care • Weight Loss Programs |

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

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

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, kwijigo 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](#) \$6,000
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$6,000 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$6,060 |

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$6,000
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$5,400 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$5,420 |

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$6,000
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$2,800 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,800 |

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