
 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 1-877-236-0844. 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 deductible ?	\$2,000 individual / \$6,000 family	Generally, you must pay all of 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 , primary care and Specialist visits, and Urgent care services 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?	Yes. Separate \$250 prescription drug deductible applies to Tiers 2-4	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	\$2,000 individual / \$6,000 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 ?	N/A	This plan does not use a provider network . You can receive covered services from any provider .
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
<p>If you visit a health care provider's office or clinic</p>	<p>Primary care visit to treat an injury or illness</p>	<p>Preferred PCP: \$10 copay; deductible does not apply All others: \$25 copay; deductible does not apply</p>	<p>Copay encompasses all services rendered per visit. Visit www.myemployersolutions.com for a list of preferred providers.</p>
	<p>Specialist visit</p>	<p>\$50 copay; deductible does not apply</p>	<p>Copay encompasses all services rendered per visit. Chiropractic care is limited to 26 visits per plan year. The chiropractic care plan year maximum also applies to the outpatient therapy plan year maximum.</p>
	<p>Preventive care/screening/immunization</p>	<p>No charge; deductible does not apply</p>	<p>Limited to one exam per plan year. 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.</p>
<p>If you have a test</p>	<p>Diagnostic test (x-ray, blood work)</p>	<p>0% coinsurance</p>	<p>None</p>
	<p>Imaging (CT/PET scans, MRIs)</p>	<p>0% coinsurance</p>	<p>Preauthorization is required for outpatient services. If you don't receive preauthorization, benefits will be reduced by \$400 per occurrence.</p>

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.magellanrx.com or call 1-800-424-5876.</p>	Generic drugs (Tier 1)	Retail: \$10 copay /prescription Mail Order: \$25 copay /prescription	<p>Deductible waived for Tier 1.</p> <p>\$250 Prescription Drug deductible applies to Tier 2-4.</p> <p>Covers up to a 30-day supply (retail prescription); 31-90-day supply (mail order prescription).</p> <p>Specialty drugs limited to a 30-day supply.</p>
	Preferred brand drugs (Tier 2)	Retail: \$50 copay /prescription Mail Order: \$125 copay /prescription	
	Non-preferred brand drugs (Tier 3)	Retail: \$80 copay /prescription Mail Order: \$200 copay /prescription	
	Specialty drugs (Tier 4)	20% coinsurance up to a maximum \$500 copay /prescription	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	<p>Preauthorization is required. If you don't receive preauthorization, benefits will be reduced by \$400 per occurrence.</p>
	Physician/surgeon fees	0% coinsurance	
<p>If you need immediate medical attention</p>	Emergency room care	\$150 copay ; deductible does not apply	None
	Emergency medical transportation	0% coinsurance	None
	Urgent care	\$55 copay ; deductible does not apply	None
<p>If you have a hospital stay</p>	Facility fee (e.g., hospital room)	0% coinsurance	<p>Preauthorization is required. If you don't receive preauthorization, benefits will be reduced by \$400 per occurrence.</p>
	Physician/surgeon fees	0% coinsurance	
<p>If you need mental health, behavioral health, or substance abuse services</p>	Outpatient services	\$25 copay ; deductible does not apply	None
	Inpatient services	0% coinsurance	<p>Preauthorization is required. If you don't receive preauthorization, benefits will be reduced by \$400 per occurrence.</p>

* 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
If you are pregnant	Office visits	\$25 <u>copay</u> ; <u>deductible</u> does not apply	<u>Cost Sharing</u> does not apply to <u>preventative services</u> . Depending on the type of service, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> 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 penalty.
	Childbirth/delivery professional services	0% <u>coinsurance</u>	
	Childbirth/delivery facility services	0% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	None
	<u>Rehabilitation services</u>	Professional Services: \$50 <u>copay</u> ; <u>deductible</u> does not apply All other outpatient: 0% <u>coinsurance</u>	<u>Preauthorization</u> is required. If you don't receive <u>preauthorization</u> , benefits will be reduced by \$400 per occurrence. Occupational, speech, physical, ABA and massage therapies are limited to 35 visits per plan year (rehabilitation and habilitation combined). Chiropractic manipulations are also included in the 35 visit per plan year maximum.
	<u>Habilitation services</u>		
	<u>Skilled nursing care</u>	0% <u>coinsurance</u>	<u>Preauthorization</u> is required. If you don't receive <u>preauthorization</u> , benefits will be reduced by \$400 per occurrence. Limited to 60 days per plan year.
	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	None
	<u>Hospice services</u>	0% <u>coinsurance</u>	None
If your child needs dental or eye care	Children's eye exam	Not Covered	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.

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

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 | • Hearing Aids | • Private Duty Nursing |
| • Bariatric Surgery | • Infertility Treatment | • Routine eye care (Adult) |
| • Cosmetic Surgery | • Long Term Care | • Routine Foot Care |
| • Dental Care | • Non-emergency care when traveling outside U.S. | • Weight Loss Programs |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Chiropractic Care (Limited to 26 visits per Plan year and applies to 35 visit maximum for all therapies combined)

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 Gator's Dockside Group, Inc. 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/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 1-877-236-0844.

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.

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 copayment](#) \$50
- 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$30
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,060

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 copayment](#) \$50
- 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,100
Copayments	\$900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,020

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist copayment](#) \$50
- 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,700
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,000

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