
 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 ?	\$4,000 individual / \$8,000 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. Primary care, preventive care , prescription drugs, 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?	No	You don't have to meet deductible for specific services.
What is the out-of-pocket limit for this plan ?	\$6,350 individual / \$12,700 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 ?	Yes. See www.multiplan.com or call 1- 877-952-7427 for a list of participating providers . Network applies to Practitioners and Ancillary only . Facility services are available at any location.	This plan uses a provider network for practitioner and ancillary services . 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. This plan does not use a network provider for facilities. You can receive covered services from any provider .

	<p>This plan does not access any network for facilities. Benefits for facilities and out-of-network practitioner and ancillary services are determined based on the Plan's Maximum Allowable Charge.</p> <p>Refer to the full definition of Maximum Allowable Charge, located in the Definitions section, of your plan document and summary plan description.</p>	
<p>Do you need a referral to see a specialist?</p>	<p>No</p>	<p>You can see the specialist you choose without a referral.</p>

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

 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	Office: \$100 copay / visit; deductible does not apply St. Vincent's 1 st Care: No charge; deductible does not apply	None
	Specialist visit	50% coinsurance	Acupuncture not covered. Chiropractic care is limited to 35 visits per Calendar Year; combined with occupational, physical and speech therapy.
	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 needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	50% coinsurance	Preauthorization is required. Failure to obtain preauthorization could result in a \$500 penalty.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.magellanrx.com or call 1-800-424-5876.	Generic drugs (tier 1)	Retail: 50% coinsurance up to a \$500 maximum per prescription. Mail Order: 50% coinsurance up to a \$1,000 maximum per prescription.	Deductible does not apply.
	Preferred brand drugs (tier 2)	Retail: 50% coinsurance up to a \$500 maximum per prescription. Mail Order: 50% coinsurance up to a \$1,000 maximum per prescription.	Covers up to a 30-day supply (retail prescription); up to 90-day supply (mail order prescription).
	Non-preferred brand drugs (tier 3)	Retail: 50% coinsurance up to a \$500 maximum per prescription. Mail Order: 50% coinsurance up to a \$1,000 maximum per prescription.	Prescription Drugs recommended by the HRSA or USPSTF will be covered at 100% as required by ACA.

* 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
	Specialty drugs (tier 4)	Retail: 50% coinsurance up to a \$500 maximum per prescription. Mail Order: 50% coinsurance up to a \$1,000 maximum per prescription.	Specialty drugs are limited to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	Preauthorization is required. Failure to obtain preauthorization could result in a \$500 penalty.
	Physician/surgeon fees	50% coinsurance	
If you need immediate medical attention	Emergency room care	50% coinsurance	None
	Emergency medical transportation	50% coinsurance	None
	Urgent care	Office: \$100 copay / visit; deductible does not apply St. Vincent's 1 st Care: No charge; deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	Preauthorization is required. Failure to obtain preauthorization could result in a \$500 penalty.
	Physician/surgeon fees	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$100 copay / visit; deductible does not apply	None
	Inpatient services	50% coinsurance	Preauthorization is required. Failure to obtain preauthorization could result in a \$500 penalty.
If you are pregnant	Office visits	\$100 copay / visit; deductible does not apply	Cost Sharing does not apply to preventative 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 a \$500 penalty.
	Childbirth/delivery professional services	50% coinsurance	
	Childbirth/delivery facility services	50% coinsurance	

* 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 need help recovering or have other special health needs	Home health care	50% coinsurance	None
	Rehabilitation services	50% coinsurance	Preauthorization is required. Failure to obtain preauthorization could result in a \$500 penalty. Chiropractic Care, Occupational, Physical and Speech Therapy limited to 35 visits combined per Calendar Year.
	Habilitation services		
	Skilled nursing care	50% coinsurance	Preauthorization is required. Failure to obtain preauthorization could result in a \$500 penalty. Limited to 60 days per Calendar Year.
	Durable medical equipment	50% coinsurance	None
	Hospice services	50% coinsurance	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.

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 and Child) 	<ul style="list-style-type: none"> Hearing aids Infertility treatment Long-term care Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> Private-duty nursing Routine eye care (Adult and Child) 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.)
<ul style="list-style-type: none"> Chiropractic care (35 visits per Calendar Year; combined with physical, speech and occupational therapy).

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

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 Rinaudo Enterprises, 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.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

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](#) \$4,000
- [Specialist coinsurance](#) 50%
- Hospital (facility) [coinsurance](#) 50%
- Other [coinsurance](#) 50%

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	\$4,000
Copayments	\$0
Coinsurance	\$2,400
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$6,410

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$4,000
- [Specialist coinsurance](#) 50%
- Hospital (facility) [coinsurance](#) 50%
- Other [coinsurance](#) 50%

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	\$3,900
Copayments	\$600
Coinsurance	\$400
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$4,920

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$4,000
- [Specialist coinsurance](#) 50%
- Hospital (facility) [coinsurance](#) 50%
- Other [coinsurance](#) 50%

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	\$2,600
Copayments	\$0
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,700

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