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?	**$5,000** individual / **$10,000** 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 and services listed with a copay 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 deductibles 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?	This plan does not use a provider network but some services are available for a reduced cost when rendered by Advent Health providers. See chart below for details.	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
		Advent Health Providers	All Other Providers	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay; deductible does not apply	**Preferred PCP:** $10 copay; deductible does not apply **All others:** $30 copay; deductible does not apply	Copay encompasses all services rendered per visit. For a list of preferred primary care providers see www.myemployersolutions.com
	Specialist visit	$50 copay; deductible does not apply	$60 copay; deductible does not apply **Chiropractic Care:** 20% coinsurance	Chiropractic care is limited to 20 visits per plan year.
	Preventive care/screening/ immunization	No charge; deductible does not apply	No charge; deductible does not apply	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.
If you have a test	Diagnostic test (x-ray, blood work)	**Lab:** $0 copay; deductible does not apply **X-ray:** $25 copay; deductible does not apply	**Lab:** $0 copay; deductible does not apply **X-ray:** $75 copay; deductible does not apply	None
	Imaging (CT/PET scans, MRIs)	$300 copay per scan; deductible does not apply	$400 copay per scan; deductible does not apply	Preauthorization is required. If you don't receive preauthorization, benefits will be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Advent Health Providers	All Other Providers	
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)	$10 copay; deductible does not apply	Non-Participating Pharmacies not covered	Covers up to a 30-day supply (retail prescription); 31-90-day supply (mail order prescription). Prescription Drugs recommended by the HRSA or USPSTF will be covered at 100% as required by ACA. Specialty drugs limited to a 30-day supply. When a Member elects to use the Voluntary Specialty Rx program they will have a $0 Copay, and Dutin's BBQ will pay 100% of the Rx cost directly to the vendor.
	Preferred brand drugs (Tier 2)	$30 copay after deductible		
	Non-preferred brand drugs (Tier 3)	$50 copay after deductible		
	Specialty drugs (Tier 4)	$500 copay after deductible		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$1,500 copay; deductible does not apply	20% coinsurance	Preauthorization is required. If you don't receive preauthorization, benefits will be denied.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance		None
	Emergency medical transportation	20% coinsurance		None
	Urgent care	$50 copay; deductible does not apply	$75 copay; deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$3,000 copay; deductible does not apply	20% coinsurance	Preauthorization is required. If you don't receive preauthorization, benefits will be denied.
	Physician/surgeon fees	20% coinsurance	20% 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
		Advent Health Providers	All Other Providers	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay; deductible does not apply		None
	Inpatient services	$3,000 copay; deductible does not apply		Preauthorization is required. If you don't receive preauthorization, benefits will be denied.
If you are pregnant	Office visits	$10 copay; deductible does not apply	$30 copay; 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 claim denial.
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	$3,000 copay; deductible does not apply	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance		Preauthorization is required. If you don't receive preauthorization, benefits will be denied. Limited to 60 visits per plan year.
	Rehabilitation services	20% coinsurance		Preauthorization is required after six (6) visits. If you don't receive preauthorization, benefits will be denied. Occupational, speech and physical therapies are limited to 30 combined visits per plan year for rehabilitation/habilitation. Benefit includes the diagnosis, testing and treatment of autism, ADD or ADHD.
	Habilitation services			
	Skilled nursing care	20% coinsurance		Preauthorization is required. If you don't receive preauthorization, benefits will be denied. Limited to 60 days per plan year.
	Durable medical equipment	20% coinsurance		None
	Hospice services	20% coinsurance		Preauthorization is required. If you don't receive preauthorization, benefits will be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Advent Health Providers	All Other Providers	
If your child needs dental or eye care	Children's eye exam	Primary Care: $30 copay; deductible does not apply Specialist: $60 copay; deductible 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 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
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside U.S.
- Private Duty Nursing
- 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.)

- Chiropractic Care (20 visits per plan 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 Dustin's BBQ 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.

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

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, kwiijigo 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	$5,000
Specialist copayment	$60
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	$5,000
Copayments	$200
Coinsurance	$1,200
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	$5,000
Specialist copayment	$60
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	$3,900
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4,420**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$5,000
Specialist copayment	$60
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	$2,300
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,600**

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