Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Iron PLATINUM

Coverage Period: Beginning on or after 01/01/2020

Coverage for: Individual / Family | Plan Type: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.IronReHealth.com or by calling 1-833-BENEBAY.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	IN NETWORK $100/Individual or $200/Family OUT OF NETWORK $100/Individual or $200/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 primary care services are covered before you meet your **deductible**.	This **plan** covers some items and services even if you haven't 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 services deductibles for specific services?	Yes. **$300** per admission for out-of-network hospital stay. There are no other specific **deductibles.**	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?	For **network providers** $4,000 individual / $8,000 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. (There are no out of network, out of pocket maximum limits. Once OOP has been met no further benefits will be paid)
What is not included in the out-of-pocket limit?	**Copayments** for certain services, **premiums**, **balance-billing charges**, 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. Visit www.carevalet.com or call 1-833-BENEBAY for a list of **network 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.	This **plan** does not require you to seek a referral from your **primary care physician** prior to seeing a **specialist**.

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 Network Provider (You will pay the least)		Out-of-Network Provider (You will pay the most)	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	Covered at 100% of the allowed amount after $20 physician copay		Subject to 50% Coinsurance and deductible	None
	Specialist visit	Covered at 100% of the allowed amount after $30 physician copay		Subject to 50% Coinsurance and deductible	Preauthorization required
	Preventive Care/Screening Immunization	$0 (No Charge)		Not Covered	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	Laboratory (Procedure & Pathology) – Physician Office	Covered at 100% of the allowed amount; no copay or deductible		Subject to 20% Coinsurance and deductible	None
	X-ray - Imaging	Covered at 100% of the allowed amount; no copay or deductible		Subject to 20% Coinsurance and deductible	
	Diagnostic (CT/PET scans, MRIs, Ultrasound	Covered at 100% of the allowed amount; no copay or deductible		Subject to 20% Coinsurance and deductible	Preauthorization required
If you need drugs to treat your illness or condition	Generic drugs	Retail $10	Mail Order $25	Not Covered	Covers up to a 30 day supply (retail subscription); 31-90 day supply (mail order prescription).
	Brand drugs	Retail $35	Mail Order $87.50	Not Covered	
	Non-Preferred drugs	Retail $75	Mail Order $187.50	Not Covered	
	Specialty	Retail $200	Mail Order N/A	Not Covered	

If you have outpatient surgery	Facility fee (e.g., ambulatory Surgery center)	Covered at 100% of the allowed amount after $150 Copay	Subject to 20% Coinsurance and deductible	Preauthorization required
	Physician/surgeon fees Anesthesia	Covered at 100% of the allowed amount after deductible has been met	Subject to 20% Coinsurance and deductible	

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)	
OUTPATIENT **If you need immediate medical attention**	Emergency room care	Covered at 100% of the allowed amount after $150 Copay	Covered at 100% of the allowed amount after $150 Copay	Physician charges will apply
	Emergency medical transportation (Ambulance / Air Transportation)	Subject to 20% Coinsurance and deductible	Subject to 20% Coinsurance and deductible	None
	Urgent care	Covered at 100% of the allowed amount after $20 physician copay	Subject to 20% Coinsurance and deductible	
INPATIENT **If you have a hospital stay**	Facility Fee (e.g., hospital room)	Covered at 100% of the allowed amount after $150 Copay per day (Days 1-5)	$300 per admission Copay & 20% coinsurance	Preauthorization required
	Physician/surgeon fees	Covered at 100% of the allowed amount after deductible has been met	Subject to 20% Coinsurance and deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 Copay per visit	Subject to 20% Coinsurance and deductible	Preauthorization required
	Inpatient services (Physician Services)	Covered at 100% of the allowed amount after deductible has been met	Subject to 20% Coinsurance and deductible	

If you are pregnant	Office visits	Covered at 100% of the allowed amount after deductible has been met	Subject to 20% Coinsurance and deductible	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the Summary (i.e. ultrasound)
	Childbirth/delivery professional services	Covered at 100% of the allowed amount after deductible has been met	Subject to 20% Coinsurance and deductible	
	Childbirth/delivery facility services and Maternity Hospitalization	Covered at 100% of the allowed amount after $150 Copay per day (Days 1-5)	$300 per admission Copay & 20% coinsurance	
If you need help recovering or have other special health needs	Home health care	Covered at 100% of the allowed amount after deductible has been met	Subject to 20% Coinsurance and deductible	Preauthorization required
If you need help recovering or have other special health needs	Rehabilitation services	Subject to 20% Coinsurance and deductible	Subject to 20% Coinsurance and deductible	30 visits per member per calendar year; includes occupational, physical and speech therapy; children ages 0-18 with an autism diagnosis are allowed unlimited visits for occupational and speech therapy.
	Habilitation services	Subject to 20% Coinsurance and deductible	Subject to 20% Coinsurance and deductible	30 visits per member per calendar year; includes occupational, physical and speech therapy; children ages 0-18 with an autism diagnosis are allowed unlimited visits for occupational and speech therapy.
	Skilled nursing care	Not Covered	Not Covered	Not covered member pays 100%
	Durable medical equipment	Subject to 20% Coinsurance and deductible	Subject to 20% Coinsurance and deductible	None
	Hospice services	Covered at 100% of the allowed amount after deductible has been met	Subject to 20% Coinsurance and deductible	Preauthorization required

If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services (This isn't a complete list) Please see your plan document for a more comprehensive list of excluded services.

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information)		
Abortion (except in cases of rape, incest, or when life Of the mother is endangered)	Dental Care (Adults)	Private-duty nursing
Acupuncture	Hearing aids	Routine foot care
Bariatric surgery	Long Term Care	Weight loss programs
Cosmetic surgery	Non-emergency care when traveling outside the U.S.	

Other Covered Services (Limitations may apply to these services. Please see your plan document.)
Chiropractic care (15 visits per calendar year)

Carrier Plan Name	Cigna Iron Platinum		
Deductible *Individual* *Family*	 $100 $200		
Coinsurance (Amount Member pays)	20%		
Out of Pocket Maximum includes: Individual Family (Individual / Family Aggregate)	*Includes Deductible, Coinsurance & Rx* $4,000 $8,000		
Facility Services			
In-Patient Hospital Outpatient Surgery Emergency Room Urgent Care	Covered at 100% after $150 copay per day (Days 1 – 5) $150 Copay per service $150 copay per visit $20 copay per visit		
Physician Services			
Preventive Primary Care Physician Specialist Primary Care Physician Selection Required?	$0 copay $20 $30 No		
Independent Lab and Diagnostic Testing Services			
Lab X-Ray Advanced Imaging (MRI, PET, CT, ULTRASOUND, etc.)	100% coverage (Physician's Office) 100% coverage (Physician's Office) 100% coverage (Physician's Office)		
Prescriptions		**Retail**	**Mail Order**
	Generic:	$10	$25
	Brand:	$35	$87.50
	Non-Preferred:	$75	$187.50
	Specialty:	$200	N/A
Out of Network Benefits	**Out of Network**		
Deductible (*Individual / Family)* **Coinsurance** *(Amount Member Pays)*	$100 / $200 20%		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. See your HR/Benefit coordinator for COBRA information or visit Florida State, HHS, DOL and/or other applicable agency contact information. 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 call1-800-318-2596.

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 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 1-833-BENEBAY.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

- For more information about limitations and exceptions, see the plan or policy document.