Summary of Benefits and Coverage: What this Plan Covers & What it Costs
Wellness 5000

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 $5,000/Individual or $10,000/Family OUT OF NETWORK $5,000/Individual or $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 deductibles?	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?	No.	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** $7,900 individual / $15,800 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?	**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 $35 physician copay	Office Visit 50% coinsurance after deductible	None
	Specialist visit	Covered at 100% of the allowed amount after $50 physician copay	Office Visit 50% coinsurance after deductible	Preauthorization required
	Preventive Care/Screening Immunization	$0 (No Charge)	Office Visit 50% coinsurance after deductible	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)	Covered at 80% of the allowed amount after deductible has been met	50% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs, Ultrasound	Covered at 80% of the allowed amount after deductible has been met	50% coinsurance after deductible	Preauthorization required
If you need drugs to treat your illness or condition	Generic drugs	Retail $15 / Mail Order $37.50	50% coinsurance after deductible	Covers up to a 30 day supply (retail subscription); 31-90 day supply (mail order prescription).
	Brand drugs	Retail $60 / Mail Order $150	50% coinsurance after deductible	
	Non-Preferred drugs	Retail $90 / Mail Order $225	50% coinsurance after deductible	
	Specialty	Retail 25%, $500 Min / Mail Order N/A	50% coinsurance after deductible	
If you have outpatient surgery	Facility fee (e.g., ambulatory Surgery center)	Covered at 80% of the allowed amount after deductible has been met	50% coinsurance after deductible	Preauthorization required
	Physician/surgeon fees	Covered at 80% of the allowed amount after deductible has been met	50% coinsurance after deductible	

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 need immediate medical attention	Emergency room care	Covered at 80% of the allowed amount after deductible has been met	50% coinsurance after deductible	None
	Emergency medical transportation (Ambulance / Air Transportation)	Covered at 80% of the allowed amount after deductible has been met	50% coinsurance after deductible	3 visits per calendar year
	Urgent care	Covered at 100% of the allowed amount after $50 physician copay	50% coinsurance after deductible	
If you have a hospital stay	Facility Fee (e.g., hospital room)	Covered at 80% of the allowed amount after deductible has been met	50% coinsurance after deductible	None
	Physician/surgeon fees	Covered at 80% of the allowed amount after deductible has been met	50% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Covered at 100% of the allowed amount after $50 Copay	50% coinsurance after deductible	Preauthorization required
	Inpatient services	Covered at 80% of the allowed amount after deductible has been met	50% coinsurance after deductible	
If you are pregnant	Office visits	Covered at 100% of the allowed amount after $35 physician copay	50% coinsurance after 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 $50 physician copay	50% coinsurance after deductible	
	Childbirth/delivery facility services	Covered at 80% of the allowed amount after deductible has been met	50% coinsurance after deductible	
				60 day maximum per Calendar Year (includes outpatient private duty

If you need help recovering or have other special health needs	Home health care	Covered at 80% of the allowed amount after deductible has been met	50% coinsurance after deductible	nursing when approved as Medically Necessary) 16-hour maximum per day Preauthorization required
If you need help recovering or have other special health needs	Rehabilitation services	Covered at 80% of the allowed amount after deductible has been met	50% coinsurance after deductible	60 visits per Calendar year combined for Pulmonary Rehabilitation, Cognitive, Physical, Speech, and Occupational Therapy. Cardiac Rehabilitation. Preauthorization required
	Skilled nursing care	Covered at 80% of the allowed amount after deductible has been met	50% coinsurance after deductible	Preauthorization required
	Durable medical equipment	Covered at 80% of the allowed amount after deductible has been met	50% coinsurance after deductible	Preauthorization required
	Hospice services	Covered at 80% of the allowed amount after deductible has been met	50% coinsurance after deductible	None
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)		
Bariatric Surgery	Long Term Care	Routine eye care (Adult)
Cosmetic Surgery	Non-emergency care	Routine Foot Care
Dental Care	when traveling outside the U.S	Weight Loss Programs
Hearing Aids		

Other Covered Services (Limitations may apply to these services. Please see your plan document.)
Acupuncture (if prescribed for rehabilitation purposes) (20 visits per Calendar Year) Subject to deductible and coinsurance.
Chiropractic Care (20 visits per Calendar Year) Subject to deductible and coinsurance.

Carrier Plan Name	Cigna Wellness 5000		
Deductible *Individual* *Family*	 $5,000 $10,000		
Coinsurance (Amount Member pays)	20%		
Out of Pocket Maximum includes: Individual Family (Individual / Family Aggregate)	*Includes Deductible, Coinsurance & Rx* $7,900 $15,800		
Facility Services			
In-Patient Hospital Outpatient Surgery Emergency Room Urgent Care	Deductible / Coinsurance Deductible / Coinsurance Deductible / Coinsurance $50		
Physician Services			
Preventive Primary Care Physician Specialist Primary Care Physician Selection Required?	$0 $35 $50 No		
Independent Lab and Diagnostic Testing Services			
Lab X-Ray Advanced Imaging (MRI, PET, CT, etc.)	Deductible / Coinsurance Deductible / Coinsurance Deductible / Coinsurance		
Prescriptions		**Retail**	**Mail Order**
	Generic:	$15	$37.50
	Brand:	$60	$150
	Non-Preferred:	$90	$225
	Specialty:	25%, $500 Min	N/A
Out of Network Benefits	**Out of Network**		
Deductible (*Individual / Family)* **Coinsurance** *(Amount Member Pays)*	$5,000 / $10,000 50%		

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.