



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

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-BENEBAAY.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<p>IN NETWORK \$2,600/Individual or \$5,200/Family</p> <p>OUT OF NETWORK \$2,600/Individual or \$5,200/Family</p>	<p>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.</p>
Are there services covered before you meet your deductible?	<p>Yes. Preventive Care and primary care services are covered before you meet your deductible.</p>	<p>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</p>
Are there services deductibles for specific services?	<p>Yes. \$1,400 per admission for out-of-network hospital stay. There are no other specific deductibles.</p>	<p>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.</p>
What is the out-of-pocket limit for this plan?	<p>For network providers \$7,350 individual / \$14,700 family.</p>	<p>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)</p>
What is not included in the out-of-pocket limit?	<p>Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
Will you pay less if you use a network provider?	<p>Yes. Visit www.carevalet.com or call 1-833-BENEBAAY for a list of network providers.</p>	<p>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.</p>
Do you need a referral to see a specialist?	<p>No.</p>	<p>This plan does not require you to seek a referral from your primary care physician prior to seeing a specialist.</p>

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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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 \$40 physician copay	Subject to 50% Coinsurance and deductible	None
	Specialist visit	Covered at 100% of the allowed amount after \$65 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 50% Coinsurance and deductible	None
	X-ray - Imaging	Covered at 100% of the allowed amount; no copay or deductible	Subject to 50% Coinsurance and deductible	
	Diagnostic (CT/PET scans, MRIs, Ultrasound)	Covered at 100% of the allowed amount after \$400 Copay	Subject to 50% Coinsurance and deductible	Preauthorization required
If you need drugs to treat your illness or condition	Generic drugs	Retail \$15	Mail Order \$37.50	Covers up to a 30 day supply (retail subscription); 31-90 day supply (mail order prescription).
	Brand drugs	Retail \$65	Mail Order \$162.50	
	Non-Preferred drugs	Retail \$100	Mail Order \$250	
	Specialty	Retail \$250	Mail Order N/A	

If you have outpatient surgery	Facility fee (e.g., ambulatory Surgery center)	Covered at 100% of the allowed amount after \$390 Copay	Subject to 50% Coinsurance and deductible	Preauthorization required
	Physician/surgeon fees Anesthesia	Covered at 100% of the allowed amount after deductible has been met	Subject to 50% 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 \$400 Copay	Covered at 100% of the allowed amount after \$400 Copay	Physician charges will apply
	Emergency medical transportation (Ambulance / Air Transportation)	Subject to 20% coinsurance and deductible	Subject to 50% Coinsurance and deductible	None
	Urgent care	Covered at 100% of the allowed amount after \$40 physician copay	Subject to 50% Coinsurance and deductible	
INPATIENT If you have a hospital stay	Facility Fee (e.g., hospital room)	Covered at 100% of the allowed amount after \$390 Copay per day (Days 1-5)	\$1,400 per admission Copay & 50% coinsurance	Preauthorization required
	Physician/surgeon fees	Covered at 100% of the allowed amount after deductible has been met	Subject to 50% Coinsurance and deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$65 Copay per visit	Subject to 50% Coinsurance and deductible	Preauthorization required
	Inpatient services (Physician Services)	Covered at 100% of the allowed amount after deductible has been met	Subject to 50% Coinsurance and deductible	

If you are pregnant	Office visits	Covered at 100% of the allowed amount after deductible has been met	Subject to 50% 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 50% Coinsurance and deductible	
	Childbirth/delivery facility services and Maternity Hospitalization	Covered at 100% of the allowed amount after \$390 Copay per day (Days 1-5)	\$1,400 per admission Copay & 50% 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 50% 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 50% 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 50% 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 50% Coinsurance and deductible	None
	Hospice services	Covered at 100% of the allowed amount after deductible has been met	Subject to 50% 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 (Adult)	Private-duty nursing
Acupuncture	Hearing aids	Routine eye care (Adult)
Bariatric surgery	Long-term care	Routine foot care
traveling outside the U.S. Cosmetic surgery	Non-emergency care when	Weight loss programs
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 Silver		
Deductible <i>Individual</i> <i>Family</i>	\$2,600 \$5,200		
Coinsurance (Amount Member pays)	20%		
Out of Pocket Maximum includes: Individual Family (Individual / Family Aggregate)	<i>Includes Deductible, Coinsurance & Rx</i> \$7,350 \$14,700		
Facility Services			
In-Patient Hospital Outpatient Surgery Emergency Room Urgent Care	Covered at 100% after \$390 copay per day (Days 1-5) \$390 Copay per service \$400 copay per visit \$40 copay per visit		
Physician Services			
Preventive Primary Care Physician Specialist Primary Care Physician Selection Required?	\$0 copay \$40 \$65 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) \$400 copay (Physician's Office)		
Prescriptions		Retail	Mail Order
	Generic:	\$15	\$37.50
	Brand:	\$65	\$162.50
	Non-Preferred:	\$100	\$250
Specialty:	\$250	N/A	
Out of Network Benefits			
Deductible (<i>Individual / Family</i>) Coinsurance (<i>Amount Member Pays</i>)	Out of Network \$2,600 / \$5,200 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 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 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-BENEBAAY.

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.