

This is a summary of benefits for your PPO plan. All deductibles and plan out-of-pocket maximums accumulate in one direction toward in-network unless otherwise noted. Plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between in- and out-of-network unless otherwise noted. CIGNA Pharmacy plan deductibles, out-of-pocket maximums, copays and annual maximums do not integrate with the employer medical program.

CIGNA HealthCare Benefit Summary Florida
Standard PPO
PPO \$1,500 Coinsurance Plan

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	\$5,000,000	\$5,000,000
Coinsurance Levels	20%	40% of Maximum Allowable Charge
Calendar Year Deductible		
<i>Individual</i>	\$1,500 per person	\$1,500 per person
<i>Family Maximum</i>	\$3,000 per family	\$3,000 per family
Out-of-Pocket Maximum		
<i>Includes Deductible</i>	No	No
<i>Includes Copays</i>	No	No
<i>Does not apply to</i>	Non-compliance penalties, deductibles, copays or charges for mental health, alcohol and drug abuse benefits.	Non-compliance penalties, deductibles, copays or charges for mental health, alcohol and drug abuse benefits or charges in excess of Maximum Allowable Charge
<i>Individual</i>	\$3,000 per person	\$3,000 per person; same as in network
<i>Family Maximum</i>	\$6,000 per family	\$6,000 per family, same as in network

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Services <i>Primary Care Physician's Office visit</i> <i>Specialty Care Physician's Office Visit</i>	20% after plan deductible; 20% after plan deductible if only x-ray and/or lab services performed and billed 20% after plan deductible; 20% after plan deductible if only x-ray and/or lab services performed and billed	40% after plan deductible 40% after plan deductible
Preventive Care <i>Routine Preventive Care</i> <i>Immunizations</i>	20% up to a max of \$250. 20% up to a max of \$250.	40% up to a max of \$250. 40% up to a max of \$250.
Mammograms, PSA, Pap Smear Note: Preventive care related services and diagnostic related services are paid at the same level of benefits as other x-ray and lab services, based on place of service.	20% up to a max of \$250.	40% up to a max of \$250.
Inpatient Hospital - Facility Services <i>Semi Private Room and Board</i> <i>Private Room</i> <i>Special Care Units (ICU/CCU)</i>	20% after plan deductible Limited to semi-private room negotiated rate Limited to semi-private room negotiated rate Limited to negotiated rate	40% after plan deductible Limited to semi-private room rate Limited to semi-private room rate Limited ICU/CCU daily room rate
Outpatient Facility Services and Professional Services <i>Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room</i>	20% after plan deductible	40% after plan deductible
Inpatient Hospital Physician's Visits/Consultations	20% after plan deductible	40% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><i>Emergency and Urgent Care Services</i></p> <p><i>Hospital Emergency Room</i></p> <p><i>Urgent Care Facility or Outpatient Facility</i></p> <p><i>Ambulance</i></p>	<p>20% after plan deductible</p> <p>20% after plan deductible</p> <p>20% after plan deductible</p>	<p>20% after plan deductible (except if not a true emergency, then 40% after plan deductible)</p> <p>20% after plan deductible (except if not a true emergency, then 40% after plan deductible)</p> <p>20% after plan deductible (except if not a true emergency, then 40% after plan deductible)</p>
<p><i>Inpatient Services at Other Health Care Facilities</i> <i>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</i></p> <p>100 days combined maximum per lifetime</p>	<p>20% after plan deductible</p>	<p>40% after plan deductible</p>
<p><i>Laboratory and Radiology Services</i> <i>(includes pre-admission testing)</i></p> <p><i>Advanced Radiological Imaging</i> <i>(i.e. MRI's, CAT Scans and PET Scans)</i></p> <p>Note: The copay applies on a per procedure basis, for any place of service</p> <p><i>Other Laboratory and Radiology Services</i></p> <p>Physician's Office</p> <p>Outpatient Hospital Facility</p> <p>Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)</p> <p>Independent X-ray and/or Lab Facility</p> <p>Independent X-ray and/or Lab Facility in conjunction with an ER visit</p>	<p>20% after plan deductible</p> <p>20% after plan deductible</p> <p>20% after plan deductible</p> <p>20% after plan deductible (if the ER/UC facility is covered subject to plan coinsurance and deductible)</p> <p>20% after plan deductible</p> <p>20% after plan deductible (if the ER facility is covered subject to plan coinsurance and deductible)</p>	<p>40% after plan deductible</p> <p>40% after plan deductible</p> <p>40% after plan deductible</p> <p>20% after plan deductible (if the ER/UC facility is covered subject to plan coinsurance and deductible) (except if not a true emergency, then 40% after plan deductible)</p> <p>40% after plan deductible</p> <p>20% after plan deductible (if the ER facility is covered subject to plan coinsurance and deductible) (except if not a true emergency, then 40% after plan deductible)</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<i>Outpatient Short-Term Rehabilitative Therapy Services</i> 20 visits combined maximum per calendar year Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy	20% after plan deductible; 20% after plan deductible if only x-ray and/or lab services performed and billed.	40% after plan deductible
<i>Chiro Services</i> 10 visit combined maximum per calendar year	20% after plan deductible; 20% after plan deductible if only x-ray and/or lab services performed and billed.	40% after plan deductible
<i>Home Health Care</i> 60 day maximum per calendar year (includes outpatient private duty nursing when approved as medically necessary)	20% after plan deductible	40% after plan deductible
<i>CIGNA Pharmacy Prescription Drugs</i>	20%/20%/20%	20%/20%/20%
<i>Pharmacy Deductible</i>	Must satisfy medical deductible	Must satisfy medical deductible
<i>Pharmacy Out of Pocket Maximum</i>	None	None
<i>CIGNA Tel-Drug Mail Order Drug Program</i>	20%/20%/20%	20%/20%/20%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Mental Health) <i>Inpatient</i></p> <p><i>Substance Abuse – Inpatient</i></p> <p><i>Outpatient MH</i></p> <p><i>Outpatient Alcohol and SA Treatment</i></p>	<p>MH - 20% after plan deductible 10 days combined maximum per calendar year</p> <p>SA – 20% after plan deductible; inpatient or outpatient treatment or a combination of both is subject to a lifetime max of \$2,000.</p> <p>20% after plan deductible subject to 20 visits per year with a max allowance of \$50 per visit.</p> <p>20% after plan deductible; 44 visit combined maximum per year. There is a max allowance of \$35 per visit.</p>	<p>40% after plan deductible; 5 days combined maximum per calendar year</p> <p>SA – 40% after plan deductible; inpatient or outpatient treatment or a combination of both is subject to a lifetime max of \$2,000.</p> <p>40% after plan deductible subject to 10 visits per year with a max allowance of \$50 per visit.</p> <p>40% after plan deductible; 44 visit combined maximum per year. There is a max allowance of \$35 per visit to a max of \$2,000</p>
<p>Pre-Admission Certification - Continued Stay Review</p> <p>*CIGNA's PAC/CSR is not necessary for Medicare Primary individuals</p> <p>Inpatient Pre-Admission Certification - Continued Stay Review (required for all inpatient admissions)</p> <p>Outpatient Pre-Certification (required for selected outpatient procedures and diagnostic testing)</p>	<p>Coordinated by Provider/PCP</p>	<p>Mandatory: Employee is responsible for contacting CIGNA Healthcare. Penalties for non- compliance:</p> <ul style="list-style-type: none"> • 20% penalty applied to hospital inpatient charges for failure to contact CIGNA Healthcare to precertify. • Benefits are denied for any admission reviewed by CIGNA Healthcare and not certified. • Benefits are denied for any additional days not certified by CIGNA Healthcare.

This Benefit Summary highlights some of the benefits available under your plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your Group Service Agreement or Certificate.

Benefits are insured and/or administered by Connecticut General Life Insurance Company.

"CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, CIGNA Vision Care, Inc., Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc. "CIGNA Tel-Drug" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C., which are also operating subsidiaries of CIGNA Corporation.

