

Individual & Family Plans

Insured by Cigna Health and Life Insurance Company



► FLORIDA - SOUTH FLORIDA, ORLANDO AND TAMPA

myCigna Medical Plan

SUMMARY OF BENEFITS

Your 2015 plan information

This plan is available to residents in parts of Florida, depending on county. Please see last page for full listing.

myCigna Health Flex 5000 Bronze

MEDICAL

IN-NETWORK

OUT-OF-NETWORK



This medical plan uses the Cigna LocalPlus® Network of participating health care professionals which offers referral-free access to a smaller network of participating health care professionals (physicians, hospitals, etc.) than the larger Cigna OAP Network. To minimize your out-of-pocket expenses, visit health care providers in the LocalPlus Network. If you choose to visit a health care professional out-of-network (OON) you will be reimbursed at the OON benefit level. The difference in the amount that Cigna reimburses for such services and the amount charged by the physician, hospital or professional except for emergency services, will also increase your OON costs.

In-network

- LocalPlus health care professionals in the LocalPlus service area for this plan
- LocalPlus health care professionals in other LocalPlus service areas
- In service areas where the LocalPlus Network is not available, customers can access doctors and hospitals in Cigna's national Away From Home (Open Access Plus) Network and receive coverage at the in-network level
- Any visit considered an emergency as defined by your policy

Out-of-network

- Any professional in your LocalPlus service area that is not part of the LocalPlus Network
- Professionals in other LocalPlus service areas that are not part of the LocalPlus Network
- Non-Cigna contracted professionals in any area

For more detailed information or to find providers in the LocalPlus Network, including participating providers when you are away from home, please review the LocalPlus Network flyer, visit www.Cigna.com/ifp-providers or call 1.800.Cigna24.

| | | |
|--|------------------------------|------------------------------|
| Individual Deductible (Medical and pharmacy) | \$5,000 | \$12,500 |
| Family Deductible (Medical and pharmacy) | \$10,000 | \$25,000 |
| Individual/family deductible is satisfied when each member has reached their annual individual deductible or when the total annual family deductible amount has been reached by any combination of family members. | | |
| Coinsurance* | You pay 40% after deductible | You pay 50% after deductible |
| Individual Out-of-Pocket Maximum | \$6,500 | \$25,000 |
| Family Out-of-Pocket Maximum | \$13,000 | \$50,000 |

Individual/family copays, deductibles, coinsurance and pharmacy charges apply to the out-of-pocket maximum.

*Amount you pay for covered medical services. Out-of-network you may pay more, if the provider's charges exceed the amount Cigna reimburses for billed services.

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|--|---|--|
| MEDICAL | IN-NETWORK | OUT-OF-NETWORK |
| PHYSICIAN SERVICES | | |
| Primary Care Physician (Office visit) | You pay \$15 per visit, deductible waived | You pay 50% after deductible |
| Specialist Physician (Office visit) | You pay 40% after deductible | You pay 50% after deductible |
| Office Related Services | You pay 40% after deductible | You pay 50% after deductible |
| PREVENTIVE CARE | | |
| Preventive Care for All Ages (Routine physicals and other preventive services) | You pay 0%, deductible waived | You pay 50% after deductible |
| INPATIENT SERVICES | | |
| Facility Services (Inpatient room and board, lab & x-ray, operating room, etc.) | You pay 40% after deductible | You pay 50% after deductible |
| Physician Services | You pay 40% after deductible | You pay 50% after deductible |
| MATERNITY CARE | | |
| Prenatal and Postnatal Care | You pay 40% after deductible | You pay 50% after deductible |
| Delivery and Inpatient Services for Maternity Care (Inpatient / Professional) | You pay 40% after deductible / You pay 40% after deductible | You pay 50% after deductible / You pay 50% after deductible |
| OUTPATIENT SERVICES | | |
| Lab, X-ray and Ultrasound | You pay 40% after deductible | You pay 50% after deductible |
| CT/PET Scans and MRI | You pay 40% after deductible | You pay 50% after deductible |
| Cardiac & Pulmonary Rehabilitation Subject to Short-Term Rehabilitative Therapy maximum | You pay 40% after deductible | You pay 50% after deductible |
| Short-Term Rehabilitative Therapy Cardiac & Pulmonary, Occupational, Chiropractic, Physical and Speech therapies - Calendar year maximum of 35 visits, combined in- and out-of-network. | You pay 40% after deductible | You pay 50% after deductible |
| Outpatient Surgery (Facility) | You pay 40% after deductible | You pay 50% after deductible |
| Outpatient Surgery (Physician services) | You pay 40% after deductible | You pay 50% after deductible |
| Acupuncture | Not Covered | Not Covered |
| MEDICAL | IN-NETWORK | OUT-OF-NETWORK |
| EMERGENCY AND URGENT CARE SERVICES | | |
| Hospital Emergency Room | You pay 40% after deductible | You pay the same level as In-Network if it is an emergency, as defined in your plan otherwise you pay 50% after deductible |
| Urgent Care Services | You pay \$75, deductible waived | You pay the same level as In-Network if it is an emergency, as defined in your plan otherwise you pay 50% after deductible |

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| Ambulance | You pay 40% after deductible | You pay the same level as In-Network if it is an emergency, as defined in your plan otherwise you pay 50% after deductible |

OTHER HEALTH CARE FACILITIES AND SERVICES

| | | |
|--|------------------------------|------------------------------|
| Skilled Nursing Facility Calendar year maximum of 60 days, combined in- and out-of-network | You pay 40% after deductible | You pay 50% after deductible |
| Home Health Calendar year maximum of 20 visits, combined in- and out-of-network | You pay 40% after deductible | You pay 50% after deductible |
| Hospice | You pay 40% after deductible | You pay 50% after deductible |

DURABLE MEDICAL EQUIPMENT (DME)

| | | |
|----------------------------------|------------------------------|------------------------------|
| Durable Medical Equipment | You pay 40% after deductible | You pay 50% after deductible |
|----------------------------------|------------------------------|------------------------------|

MENTAL HEALTH & SUBSTANCE ABUSE

| | | |
|---|------------------------------|------------------------------|
| Inpatient (Includes acute & residential treatment) | You pay 40% after deductible | You pay 50% after deductible |
| Outpatient (Includes individual, group, intensive outpatient & partial hospitalization treatment) | You pay 40% after deductible | You pay 50% after deductible |

PRESCRIPTION DRUGS (Retail & Home Delivery)

IN-NETWORK

OUT-OF-NETWORK



In the event that you or your physician requests a "brand-name" drug that has a "generic" equivalent, you will pay the difference between the generic and brand-name drug in addition to the generic copay or coinsurance amount indicated below.

PRESCRIPTIONS FILLED AT RETAIL

Please visit www.Cigna.com/ifp-providers to review the retail pharmacies that are in-network and www.Cigna.com/ifp-drug-list to see the drugs covered under this plan.

| | | |
|--|---------------------------------|------------------------------|
| TIER 1: Retail Preferred Generics (Available at the lowest cost) Up to a 30 day supply. Note: Up to a 60 day supply for HIV/AIDS specialty medications. | You pay \$4, deductible waived | You pay 50% after deductible |
| TIER 2: Retail Non-preferred Generics (Medications at a higher cost than Tier 1) Up to a 30 day supply. Note: Up to a 60 day supply for HIV/AIDS specialty medications. | You pay \$30, deductible waived | You pay 50% after deductible |
| TIER 3: Retail Preferred Brands (Brand-name drugs at a lower cost than Tier 4) Up to a 30 day supply. Note: Up to a 60 day supply for HIV/AIDS specialty medications. | You pay 40% after deductible | You pay 50% after deductible |
| TIER 4: Retail Non-preferred Brands (A mix of non-preferred brand-name and generic drugs at a higher cost than Tier 2 and Tier 3) Up to a 30 day supply. Note: Up to a 60 day supply for HIV/AIDS specialty medications. | You pay 50% after deductible | You pay 50% after deductible |
| TIER 5: Retail Specialty (Drugs for complex chronic conditions) Up to a 30 day supply – New prescription fillable for the first time at a Retail Pharmacy, all refills required through Home Delivery. Note: Up to a 60 day supply for HIV/AIDS specialty medications. | You pay 40% after deductible** | You pay 50% after deductible |

**For Atripla, Complera, Stribild and Fuzeon the deductible/coinsurance will not exceed \$200 for a 30-day supply.

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| PRESCRIPTION DRUGS (Retail & Home Delivery) | IN-NETWORK | OUT-OF-NETWORK |
| PRESCRIPTIONS FILLED THROUGH HOME DELIVERY | | |
| Cigna Home Delivery Pharmacy SM is your in-network provider to help you save money on medications. Once you are a customer visit myCigna.com or call 1.800.285.4812 for more information. | | |
| TIER 1: Home Delivery Preferred Generics (Available at the lowest cost) Up to a 90 day supply | You pay \$10, deductible waived | You pay 50% after deductible |
| TIER 2: Home Delivery Non-preferred Generics (Medications at a higher cost than Tier 1) Up to a 90 day supply | You pay \$75, deductible waived | You pay 50% after deductible |
| TIER 3: Home Delivery Preferred Brands (Brand-name drugs at a lower cost than Tier 4) Up to a 90 day supply | You pay 40% after deductible | You pay 50% after deductible |
| TIER 4: Home Delivery Non-preferred Brands (A mix of non-preferred brand-name and generic drugs at a higher cost than Tier 3) Up to a 90 day supply | You pay 50% after deductible | You pay 50% after deductible |
| TIER 5: Home Delivery Specialty (Drugs for complex chronic conditions) Up to a 30 day supply – New prescription fillable for the first time at a Retail Pharmacy, all refills required through Home Delivery. Note: Up to a 60 day supply For HIV/AIDS specialty medications. | You pay 30% after deductible** | You pay 50% after deductible |

This summary contains highlights only.

**For Atripla, Complera, Stribild and Fuzeon the deductible/coinsurance will not exceed \$200 for a 30-day supply.

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2015 PLAN EXCLUSIONS AND LIMITATIONS

In addition to any other exclusions and limitations described in this policy, there are no benefits provided for the following:

- Any amounts in excess of maximum amounts of covered expenses stated in this policy.
- Services not specifically listed in this policy as covered services.
- Services or supplies that are not medically necessary.
- Services or supplies that Cigna considers to be for experimental procedures or investigative procedures.
- Services received before the effective date of coverage.
- Services received after coverage under this policy ends.
- Services for which you have no legal obligation to pay or for which no charge would be made if you did not have health plan or insurance coverage.
- Any condition for which benefits are paid, recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if the Insured person does not claim those benefits.
- Conditions caused by: (a) an act of war (declared or undeclared); (b) the inadvertent release of nuclear energy when government funds are available for treatment of illness or injury arising from such release of nuclear energy; (c) an Insured person participating in the military service of any country; (d) an Insured person participating in an insurrection, rebellion, or riot; (e) services received as a direct result of an Insured person's commission of, or attempt to commit a felony (whether or not charged) or as a direct result of the Insured person being engaged in an illegal occupation; (f) an Insured person being intoxicated, as defined by applicable state law in the state where the illness occurred or under the influence of illegal narcotics or non-prescribed controlled substances unless administered or prescribed by physician.
- Any services provided by a local, state or federal government agency, except when payment under this policy is expressly required by federal or state law.
- Any services required by state or federal law to be supplied by a public school system or school district.
- Any services for which payment may be obtained from any local, state or federal government agency (except Medicaid). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
- Professional services or supplies received or purchased directly or on your behalf from any of the following:
 - Yourself or your employer;
 - A person who lives in the Insured person's home, or that person's employer;
 - A person who is related to the Insured person by blood, marriage or adoption, or that person's employer.
- If the Insured person is eligible for Medicare part A, B or D, Cigna will provide claim payment according to this policy minus any amount paid by Medicare, not to exceed the amount Cigna would have paid if it were the sole insurance carrier.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a physician and listed as covered in this plan.
- Custodial Care.
- Inpatient or outpatient services of a private duty nurse.
- Inpatient room and board charges in connection with a Hospital stay primarily for environmental change or physical therapy; Custodial Care or rest cures; services provided by a rest home, a home for the aged, a nursing home or any similar facility service.
- Assistance in activities of daily living, including but not limited to: bathing, eating, dressing, or other Custodial Care, self-care activities or homemaker services, and services primarily for rest, domiciliary or convalescent care.
- Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
- Smoking cessation programs.
- Dental services, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this policy.
- Orthodontic Services, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction, except as specifically provided in this policy.
- Dental Implants Dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants.
- Hearing aids including but not limited to semi implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), except as specifically stated in this policy. For the purposes of this exclusion, a hearing aid is any device that amplifies sound.
- Routine hearing tests except as specifically provided in this policy under "Comprehensive Benefits, What the Policy Pays For".
- Genetic screening or pre-implantations genetic screening: general population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Optometric services, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this policy under Pediatric Vision.
- An eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
- Outpatient speech therapy, except as specifically stated in this policy.

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- Cosmetic surgery or other services for beautification, to improve or alter appearance or self-esteem or to treat psychological or psychosocial complaints regarding one's appearance including macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty/panniculectomy; rhinoplasty; and blepharoplasty. This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct a deformity caused by Injury or congenital defect of a Newborn child, or for Medically Necessary Reconstructive Surgery performed to restore symmetry incident to a mastectomy or lumpectomy.
- Aids or devices that assist with nonverbal communication, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books except as specifically stated in this policy.
- Nonmedical counseling or ancillary services, including but not limited to: education, vocational rehabilitation, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety.
- Services for redundant skin surgery, removal of skin tags, acupressure, acupuncture craniosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing, prolotherapy, and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, regardless of clinical indications.
- Procedures, surgery or treatments to change characteristics of the body to those of the opposite sex including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery. This also includes any medical, surgical or psychiatric treatment or study related to sex change.
- Treatment of sexual dysfunction impotence and/or inadequacy except if this is a result of an Accidental Injury, organic cause, trauma, infection, or congenital disease or anomalies.
- All services related to the evaluation or treatment of fertility and/or Infertility, including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including sterilization reversals and In vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), except as specifically stated in this plan.
- All non-prescription Drugs, devices and/or supplies, except drugs designated as preventive by the Patient Protection and Affordable Care Act (PPACA), that are available over the counter or without a prescription.
- Cryopreservation of sperm or eggs, or storage of sperm for artificial insemination (including donor fees).
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Orthopedic shoes (except when joined to braces), shoe inserts, foot orthotic devices.
- Services primarily for weight reduction or treatment of obesity including morbid obesity, or any care which involves weight reduction as a main method for treatment. This includes any morbid obesity surgery, even if the Insured person has other health conditions that might be helped by a reduction of obesity or weight, or any program, product or medical treatment for weight reduction or any expenses of any kind to treat obesity, weight control or weight reduction.
- Routine physical exams or tests that do not directly treat an actual Illness, Injury or condition, including those required by employment or government authority, physical exams required for or by an employer, or for school, or sports physicals, except as otherwise specifically stated in this plan.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Telephone, e-mail, and Internet consultations or other services which under normal circumstances are expected to be provided through face-to-face clinical encounters.
- Items which are furnished primarily for personal comfort or convenience (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification, including wigs etc.).
- Massage Therapy.
- Educational services except for Diabetes Self-Management Training Program, and as specifically provided or arranged by Cigna.
- Nutritional counseling or food supplements, except as stated in this policy.
- Durable medical equipment not specifically listed as covered services in the covered services section of this policy. Excluded durable medical equipment includes, but is not limited to: orthopedic shoes or shoe inserts; air purifiers, air conditioners, humidifiers; exercise equipment, treadmills; spas; elevators; supplies for comfort, hygiene or beautification; disposable sheaths and supplies; correction appliances or support appliances and supplies such as stockings, and consumable medical supplies other than ostomy supplies and urinary catheters, including, but not limited to, bandages and other disposable medical supplies, skin preparations and test strips except as otherwise stated in this policy.
- Physical, and/or Occupational Therapy/Medicine except when provided during an inpatient Hospital

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- confinement or as specifically stated in the Benefit Schedule and under 'Physical and/or Occupational Therapy/Medicine' in the section of the policy titled "Comprehensive Benefits What the Policy Pays For".
- Self-administered Injectable Drugs, except as stated in the Benefit Schedule and in the Prescription Drug Benefits section of this policy.
 - Any Drugs, medications, or other substances dispensed or administered in any outpatient setting except as specifically stated in this policy. This includes, but is not limited to, items dispensed by a physician.
 - Injectable drugs (self-injectable medications) that do not require physician supervision are covered under the Prescription Drug benefits of this policy.
 - All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in the Prescription Drug benefits of this policy.
 - Any Infusion or Injectable Specialty Prescription Drugs that require physician supervision, except as otherwise stated in this policy. Infusion and Injectable Specialty drugs include, but are not limited to, hemophilia factor and supplies, enzyme replacements and intravenous immunoglobulin.
 - Syringes, except as stated in the policy.
 - All Foreign Country Provider charges are excluded under this policy except as specifically stated under "Treatment received from Foreign Country Providers" in the Benefits section of this policy titled "Comprehensive Benefits What the Policy Pays For". In the event an Insured person dies outside of the United States, charges for medical evacuation and repatriation of his or her remains to the United States are not covered.
 - Growth Hormone Treatment except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the insured person's condition. Growth hormone treatment for idiopathic short stature, or improved athletic performance is not covered under any circumstances.
 - Routine foot care including the pairing and removing of corns and calluses or trimming of nails except as otherwise stated in this policy. However, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.
 - Charges for which we are unable to determine our liability because the Insured person failed, within 90 days, or as soon as reasonably possible to: (a) authorize us to receive all the medical records and information we requested; or (b) provide us with information we requested regarding the circumstances of the claim or other insurance coverage.
 - Charges for the services of a standby physician.
 - Charges for animal to human organ transplants.
 - Claims received by Cigna after 15 months from the date service was rendered, except in the event of a legal incapacity.

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2015 PLAN IMPORTANT DISCLOSURES

Rates will vary by plan design and the plan deductible, copay, coinsurance and out-of-pocket maximums selected. Rates may vary based on age, family size, geographic location (residential zip code) and tobacco use.

Rates for new medical policies with an effective date on or after 01/01/2015 are guaranteed through 12/31/2015. After the initial guarantee, rates are subject to change upon 45 days notice.

This major medical insurance policy (INDFLCH042013) has exclusions, limitations, reduction of benefits and terms under which the policy may be continued in force or discontinued. Applications are accepted during annual open enrollment period, or within 60 calendar days of a qualifying life event. Benefits are provided only for those services that are medically necessary as defined in the policy and for which the insured person has benefits. For costs, and additional details about coverage, contact Cigna Health and Life Insurance Company at 900 Cottage Grove Rd., Hartford, CT 06152 or call 1.866.GET.Cigna. (1.866.438.2446).

IMPORTANT PLAN INFORMATION

This plan is available to residents living in the following counties in Florida:

| | | | | | |
|--------------|----------|--------------|----------|------------|-------------|
| Hernando | Pasco | Brevard | Orange | Volusia | Monroe |
| Hillsborough | Pinellas | Flagler | Osceola | Broward | Palm Beach |
| Lee | Polk | Indian River | Seminole | Martin | Saint Lucie |
| Manatee | Sarasota | Lake | Sumter | Miami-Dade | |

myCigna Health Flex 5000 Bronze is a Qualified Health Plan in the Florida Health Insurance Marketplace.



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