

This is a summary of benefits for your HMO Copay plan. All in-network services must be performed by the Primary Care Physician (PCP), referred by the PCP or approved by the local Healthplan.

CIGNA HealthCare Benefit Summary	
ADVO	
CT HMO Copay Plan	
BENEFIT HIGHLIGHTS	IN-NETWORK
Lifetime Maximum	Unlimited
Coinsurance Levels	100% Note: All services will be covered at a 100% coinsurance level; with or without applicable copays
Contract Year Deductible <i>Individual</i> <i>Family Maximum</i> <i>Aggregate</i>	None None N/A
Out-of-Pocket Maximum Accumulators <i>Includes Copays</i>	Includes inpatient facility copays (including MH/SA), outpatient facility copays and advanced radiological imaging copays
<i>Includes Plan Deductibles</i>	N/A
<i>The following do not accumulate to the OOP Maximum</i> Benefits for accident or sickness (excluding mental health, alcohol, and drug abuse benefits) are paid at 100%, once an individual's out-of-pocket has been reached.	Copays not listed above Once the Out-of-Pocket Maximum is reached, plan coinsurance, inpatient facility copays (including MH/SA), outpatient facility copays and advanced radiological imaging copays will no longer be required.
Out-of-Pocket Maximum	
<i>Individual</i>	\$1,000 per person
<i>Family Maximum</i>	\$2,000 per family
<i>Aggregate</i>	Yes
Automatic Annual Reinstatement	Not Applicable
Physician's Services	
<i>Primary Care Physician's Office visit</i>	No charge after \$25 PCP per office visit copay; No charge if only x-ray and/or lab services performed and billed.
<i>Specialty Care Physician's Office Visit</i> <i>Office Visits</i> <i>Consultant and Referral Physician's Services</i> Note: OB/GYN provider is considered a Specialist.	No charge after specialist \$35 Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed.
<i>Surgery Performed In the Physician's Office</i>	No charge after \$25 PCP or \$35 Specialist per office visit copay
<i>Second Opinion Consultations (provided on a voluntary basis)</i>	No charge after \$25 PCP or \$35 Specialist per office visit copay
<i>Allergy Treatment/Injections</i>	No charge after either the \$25 PCP or \$35 Specialist per office visit copay or the actual charge, whichever is less
<i>Allergy Serum (dispensed by the physician in the office)</i>	No charge



BENEFIT HIGHLIGHTS	IN-NETWORK
<p>Preventive Care <i>Routine Preventive Care: Well-Baby, Well-Child, Adult and Well-Woman (including immunizations)</i> Note: Well-woman OB/GYN visits will be subject to the plan's Specialist copay</p>	No charge after \$25 PCP or \$35 Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed.
<p><i>Immunizations</i></p>	No charge
<p>Mammograms, PSA, PAP Smear <i>Preventive Care Related Services (i.e. "routine" services)</i></p>	No charge (for the procedure itself); professional reading charges are covered under the plan's Outpatient professional services benefit Note: The associated wellness exam is subject to the \$25 PCP or \$35 Specialist per office visit copay
<p><i>Diagnostic Related Services (i.e. "non-routine")</i></p>	Subject to the plan's x-ray & lab benefit; based on place of service
<p>Inpatient Hospital - Facility Services</p>	\$300 per admission copay, then 100%
<p><i>Semi-Private Room and Board</i></p>	Limited to the semi-private negotiated rate
<p><i>Private Room</i></p>	Limited to the semi-private negotiated rate
<p><i>Special Care Units (ICU/CCU)</i></p>	Limited to the negotiated rate
<p>Outpatient Facility Services <i>Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room.</i> Note: The copay will apply as long as services billed include one or more of the facility room charges listed above.</p>	\$125 per visit copay, then 100%
<p>Inpatient Hospital Physician's Visits/Consultations</p>	No charge
<p>Inpatient Hospital Professional Services <i>Surgeon Radiologist Pathologist Anesthesiologist</i></p>	No charge
<p>Multiple Surgical Reduction</p>	Not Applicable
<p>Outpatient Professional Services <i>Surgeon Radiologist Pathologist Anesthesiologist</i></p>	No charge

BENEFIT HIGHLIGHTS	IN-NETWORK
Emergency and Urgent Care Services	
<i>Physician's Office</i>	No charge after \$25 PCP or \$35 Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed.
<i>Hospital Emergency Room</i>	No charge after \$100 per visit copay** (Copay waived if admitted)
<i>Outpatient Professional Services (radiology, pathology, ER physician)</i>	No charge
<i>Urgent Care Facility or Outpatient Facility</i>	No charge after \$25 per visit copay** (Copay waived if admitted)
<i>Ambulance</i>	No charge ** If not a true emergency, services are not covered
Inpatient Services at Other Health Care Facilities <i>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</i> 60 days maximum per contract year (combined for all facilities listed above) No prior hospitalization required	No charge Note: If plan includes inpatient hospital copay, the copay does not apply.
Laboratory and Radiology Services <i>(includes outpatient pre-admission testing)</i>	
<i>Physician's Office</i>	No charge
<i>Outpatient Hospital Facility</i>	No charge for facility charges; no charge for outpatient professional charges
<i>Independent X-ray and/or Lab Facility</i>	No charge
<i>Independent X-ray and/or Lab Facility in conjunction with an ER visit</i>	No charge (if ER visit is considered to be a true emergency)
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans, etc.)	
<i>Inpatient Facility</i>	No charge
<i>Outpatient Facility</i>	No charge
<i>Emergency Room</i>	No charge
<i>Physician's Office</i>	No charge
Notes: • Facility copay does not apply.	

BENEFIT HIGHLIGHTS	IN-NETWORK
<p><i>Outpatient Short-Term Rehabilitative Therapy and Chiropractic Care Services</i></p> <p>Note: Maximum applies for all therapies combined</p> <p>Includes:</p> <ul style="list-style-type: none"> Physical Therapy Speech Therapy Occupational Therapy Chiropractic Therapy (includes Chiropractors) Pulmonary Rehab Cognitive Therapy Cardiac 	<p>No charge after the \$35 Specialist per visit copay ; No charge if only x-ray and/or lab services performed and billed.</p> <p>20 days combined maximum per contract year</p> <p>Note: The Outpatient Short Term Rehab copay does not apply to services provided as part of a Home Health Care visit.</p> <p>Note: Therapy days, provided as part of an approved Home health Care plan, accumulate to the Outpatient Short Term Rehab Therapy maximum. If multiple outpatient services are provided on the same day, they constitute one day, but separate copay will apply to the services provided by each Participating provider.</p>
<p><i>Home Health Care</i></p> <p>Note: Includes outpatient private nursing when approved as medically necessary.</p> <p>Maximum:</p> <p>Note: Cannot apply 16 hours per day maximum. Multiple visits can occur in one day; with a visit defined as a period of 2 hours or less</p>	<p>No charge</p> <p>80 days per contract year</p>
<p><i>Hospice</i></p> <p><i>Inpatient Services</i></p>	<p>No charge</p> <p>Note: If plan includes inpatient hospital copay, the copay does not apply.</p>
<p><i>Outpatient Services</i></p>	<p>No charge</p>
<p><i>Bereavement Counseling</i></p> <p><i>Services Provided as part of Hospice Care</i></p> <p><i>Inpatient</i></p> <p><i>Outpatient</i></p> <p><i>Services Provided by Mental Health Professional</i></p>	<p>No charge after the plan deductible</p> <p>No charge</p> <p>Covered under Mental Health benefit</p>
<p><i>Maternity Care Services</i></p> <p><i>Initial Visit to Confirm Pregnancy</i></p> <p>Note: OB/GYN visits will be subject to the plan's Specialist copay.</p>	<p>No charge after \$25 PCP or \$35 Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed</p>
<p><i>All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)</i></p>	<p>No charge</p>
<p><i>Office Visits in addition to the global maternity fee when performed by an OB or Specialist</i></p>	<p>No charge after \$35 Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed.</p>
<p><i>Delivery – Facility (Inpatient Hospital, Birthing Center)</i></p>	<p>\$300 per admission copay, then 100%</p>

BENEFIT HIGHLIGHTS	IN-NETWORK
<p>Abortion Includes elective and non-elective procedures Office Visit</p>	<p>No charge after \$25 PCP or \$35 Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed.</p>
<p>Inpatient Facility</p>	<p>\$300 per admission copay, then 100%</p>
<p>Outpatient Facility</p>	<p>\$125 per visit copay, then 100%</p>
<p>Inpatient Physician's Services</p>	<p>No charge</p>
<p>Outpatient Physician's Services</p>	<p>No charge</p>
<p>Family Planning Services Office Visit (tests, counseling) Surgical Sterilization Procedures for Vasectomy/Tubal Ligation (excludes reversals)</p>	<p>No charge after \$25 PCP or \$35 Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed. Note: Charges billed by a separate outpatient diagnostic facility will be covered under the plan's Laboratory and Radiology benefit</p>
<p>Inpatient Facility</p>	<p>\$300 per admission copay, then 100%</p>
<p>Outpatient Facility</p>	<p>\$125 per visit copay, then 100%</p>
<p>Inpatient Physician's Services</p>	<p>No charge</p>
<p>Outpatient Physician's Services</p>	<p>No charge</p>
<p>Physician's Office</p>	<p>No charge after \$25 PCP or \$35 Specialist per office visit copay</p>
<p>Infertility Treatment Coverage will be provided for the following services: <ul style="list-style-type: none"> — Testing and treatment services performed in connection with an underlying medical condition. — Testing performed specifically to determine the cause of infertility. — Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). — Artificial Insemination, In-Vitro Fertilization, GIFT, ZIFT, etc. — Oral & Injectable Infertility Drugs (includes those dispensed in the physician's office and those not dispensed in the physician's office) Oral and injectable infertility prescriptions not administered in a physician's office can be filled at any retail pharmacy. Infertility drugs dispensed in the physician's office will be covered under the medical plan at no charge after \$25 PCP or \$35 Specialist per office visit copay. </p>	<p>Applicable Copays based on place of service, then 100%.</p> <p>Maximum:</p> <ul style="list-style-type: none"> (1) limit ovulation induction to a lifetime maximum benefit of four cycles; (2) limit intrauterine insemination to a lifetime maximum benefit of three cycles; (3) limit IVF, GIFT, ZIFT and/or low tubal ovum transfers to a combined lifetime maximum of two cycles, with not more than two embryo implantations per cycle. <p>Infertility drugs dispensed at a Retail Pharmacy will need to be submitted to the medical claim address on the back of your CIGNA ID card for direct member reimbursement. The member will be reimbursed 100% of the allowable cost.</p>

BENEFIT HIGHLIGHTS	IN-NETWORK
<i>Office Visit (Lab and Radiology Tests, Counseling)</i>	No charge after \$25 PCP or \$35 Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed
<i>Inpatient Facility</i>	\$300 per admission copay, then 100%
<i>Outpatient Facility</i>	\$125 per visit copay, then 100%
<i>Physician Services</i>	No charge
Organ Transplant <i>Includes all medically appropriate, non-experimental transplants</i>	
<i>Office Visit</i>	No charge after \$25 PCP or \$35 Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed
<i>Inpatient Facility</i>	\$300 per admission copay, then 100%
<i>Inpatient Physician's Services</i>	No charge
<i>Travel Maximum</i>	\$10,000 per transplant/per lifetime maximum (only available when using a Lifesource Facility)
Durable Medical Equipment Note: services accumulate to the plan's Lifetime Maximum	No charge \$3,500 maximum per contract year. <i>Maximum does not apply to Hearing Aids for Children or Diabetic Services and Supplies.</i>
External Prosthetic Appliances Note: Services accumulate to the plan's Lifetime Maximum	No EPA deductible \$1,000 maximum per contract year. <i>Maximum does not apply to external breast prosthesis following surgical removal of breasts due to tumors.</i>
Hearing Aids for Children (Ages 12 and under)	No charge \$1,000 per 24 months.
Child Early Intervention Services Maximum:	No charge after \$25 PCP per office visit copay Maximum up to \$3,200 per child per year, and \$9,600 per child over the total 3 year period (<i>not applied to any maximum lifetime or annual benefit limits otherwise specified in the plan</i>)
Diabetes Self Management Courses	No charge after \$25 PCP per office visit copay
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.	
<i>Doctor's Office</i>	No charge after \$25 PCP or \$35 Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed
<i>Inpatient Facility</i>	\$300 per admission copay, then 100%
<i>Outpatient Facility</i>	\$125 per visit copay, then 100%
<i>Physician's Services</i>	No charge
Surgical and Non-surgical TMJ	Not Covered
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes and peripheral vascular disease.
Pre-Existing Condition Limitation	Not Applicable

BENEFIT HIGHLIGHTS	IN-NETWORK
<p>Pre-Admission Certification – Continued Stay Review Personal Health Solutions+</p> <p>CIGNA's PAC/CSR is not necessary for Medicare primary individuals</p>	
<p><i>Inpatient Pre-Admission Certification – Continued Stay Review</i> (required for all inpatient admissions)</p>	Coordinated by Provider/PCP
<p><i>Outpatient Prior Authorization</i> (required for selected outpatient procedures and diagnostic testing)</p>	Coordinated by Provider/PCP
<p>Case Management</p>	Coordinated by CIGNA HealthCare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost-effective care while maximizing the patient's quality of life.
<p>Mental Health and Substance Abuse Rehabilitative Services</p>	<p>Please note the following regarding Mental Health (MH) and Substance Abuse (SA) benefit administration:</p> <ul style="list-style-type: none"> • Substance Abuse includes Alcohol and Drug Abuse services. • Transition of Care benefits are provided for a 60 day time period. • All plans include Detox as any other illness; Substance Abuse coverage includes Inpatient rehab (except detox only). Inpatient rehab requires 24 hour nursing. Residential Substance Abuse is included; no Mental Health Residential is included.
<p>Option 5:</p> <p><i>Member Assistance Program</i></p>	1-3 Telephonic or Face-to-Face counseling sessions, information, resources and referrals for Life Events (designated non-clinical services).
<p><i>Inpatient MH&SA</i></p>	\$300 copay per admission, maximum of unlimited days
<p><i>Outpatient Mental Health</i></p>	\$35 copay per outpatient visit, maximum of unlimited visits
<p><i>Intensive Outpatient Mental Health</i></p> <p>Maximum: Unlimited programs</p>	<p>Single copay per program</p> <p>No charge after a \$105 per program copay</p>
<p><i>Mental Health Group Therapy</i></p>	\$35 copay per visit, maximum of unlimited visits
<p><i>Outpatient Substance Abuse</i></p>	\$35 copay per visit, maximum of unlimited visits
<p><i>Intensive Outpatient Substance Abuse</i></p> <p>Maximum: Unlimited programs</p>	<p>Single copay per program</p> <p>No charge after a \$105 per program copay</p> <p>Note: The Intensive Outpatient Substance Abuse benefit has replaced the prior Group Therapy Substance Abuse benefit</p>
<p>MH/SA Utilization Review & Case Management</p>	<p>Inpatient and Outpatient Management (CAP):</p> <ul style="list-style-type: none"> • CBH provides utilization review and case management for In-network Inpatient Services and In-network Outpatient Management services. • Includes Lifestyle Management Program (Stress & Tobacco)

BENEFIT HIGHLIGHTS	IN-NETWORK
<i>Prescription Drugs</i>	Prescription benefit is carved out to BCBS

Medical Benefit Exclusions (by way of example but not limited to):

Your plan provides coverage for medically necessary services. Your plan does not provide coverage for the following except as required by law:

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
4. Treatment of an illness or injury which is due to war, declared or undeclared.
5. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
6. Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
7. Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: Not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or The subject of review or approval by an Institutional Review Board for the proposed use, except as provided in the "Clinical Trials" section of "Section IV. Covered Services and Supplies;" or the subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of "Section IV. Covered Services and Supplies."
8. Cosmetic Surgery and Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
9. The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
10. Treatment of TMJ disorder.
11. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within 6 months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
12. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, including clinically severe (morbid) obesity, including: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.
13. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
14. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Section IV. Covered Services and Supplies."
15. Infertility costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
16. Reversal of male and female voluntary sterilization procedures.
17. Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
18. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
19. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.



20. Non-medical counseling or ancillary services, including, but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
21. 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.
22. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Inpatient Hospital Services," "Outpatient Facility Services," "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of "Section IV. Covered Services and Supplies."
23. Private hospital rooms and/or private duty nursing except as provided in the Home Health Services section of "Section IV. Covered Services and Supplies".
24. Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
25. Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
26. Hearing aids (except for children 12 and under), including, but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
27. Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
28. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
29. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
30. Treatment by acupuncture.
31. All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Section IV. Covered Services and Supplies."
32. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
33. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
34. Genetic screening or pre-implantation 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.
35. Dental implants for any condition.
36. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
37. Blood administration for the purpose of general improvement in physical condition.
38. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
39. Cosmetics, dietary supplements and health and beauty aids.
40. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
41. Expenses incurred for medical treatment by a person age 65 or older, who is covered under this Agreement as a retiree, or his Dependents, when payment is denied by the Medicare plan because treatment was not received from a Participating Provider of the Medicare plan.
42. Expenses incurred for medical treatment when payment is denied by the Primary Plan because treatment was not received from a Participating Provider of the Primary Plan.
43. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
44. Telephone, e-mail & Internet consultations and telemedicine.
45. Massage Therapy

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.

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