

# SUMMARY OF BENEFITS

*Your CIGNA HealthCare Open Access Plus plan*



## Features that Add Value

- Your plan offers the convenience of **referral-free access** to doctors, and the option to select a **personal Primary Care Physician (PCP)** as your source for routine care and guidance when you need specialized care. As your needs change, so may your choice of doctors. That's why you can change your PCP for any reason.
- The CIGNA HealthCare 24-Hour Health Information Line<sup>SM</sup> connects you to **trained nurses** and a **library** of hundreds of recorded programs on important health topics 24 hours a day, seven days a week, from anywhere in the U.S.
- Prescription drug coverage is a **part of your plan**. With national and independent pharmacies participating across the country, you can have your prescription filled **wherever you go**. CIGNA Home Delivery Pharmacy gives you quick, **convenient** delivery of your medications right to your home.
- **CIGNA Healthy Rewards<sup>®</sup>** includes special offers on health and wellness programs and services often not covered by many traditional benefits plans. Just call 1.800.870.3470 or visit our web site at [www.cigna.com](http://www.cigna.com).

## Quality Service Is Part of Quality Care

- **Service** is at the heart of everything we do. Our goal is to give you: fast, accurate answers; responsive, courteous and professional assistance; and ease and convenience in finding the information you need to manage your health.
- **www.cigna.com** – Visit our **interactive Web site** to learn more about your plan and get health information, 24 hours a day. Once you enroll, register for myCIGNA.com, our convenient, secure web site that combines helpful easy-to-use tools with personalized benefits information to help you make the most of your plan.
- **We Speak Many Languages<sup>SM</sup>**. We offer Language Line Services so that you can **talk with us** in 150 different languages. Just call Customer Service and ask for an interpreter to assist you.

## It's Your Health

When you choose CIGNA HealthCare, you can take advantage of our **health and wellness** programs:

- We encourage you to use a **PCP** as a valuable resource and personal health advocate.
- **Preventive care services** for every covered family member.
- **CIGNA Well Informed** provides members with customized medical and wellness information to help them make healthier choices, better understand a diagnosis or treatment, and manage their health. The program includes personalized letters and other educational information to help you improve your health. Only you, your doctor and CIGNA have access to this information.
- The CIGNA HealthCare Healthy Babies<sup>®</sup> program provides you with information to help you have a **healthy pregnancy and a healthy baby**.

## You Can Depend on CIGNA HealthCare

- **Quality comes first**. We select “preferred providers” carefully. And we make sure you have a **wide range** of doctors to choose from.
- **Emergency and urgent care are covered** wherever you go, worldwide, **24 hours a day**. Urgent care centers can take care of your urgent care needs, and your cost is lower.

## It's Your Choice

- When you visit network providers, you get access to quality care at the lowest out-of-pocket costs. Your plan also offers the freedom to choose the providers you prefer — even if they aren't part of the network. Your benefits are the highest when you see “preferred providers,” but you're still covered for visits to other providers. Participating providers charge a discounted rate for CIGNA members. If you use a non-network provider, the provider may bill you for the difference between the billed charge and the allowed amount under your benefit plan, in addition to applicable (higher than in-network) deductibles and coinsurance amounts.

*For Participants of:  
Equity-League Health Trust Fund  
Open Access Plus Copay Plan*

## Notice of Grandfathered Plan Status

**This plan is being treated as a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your coverage may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.**

**Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at the phone number or address provided in your plan documents, to your employer or plan sponsor or an explanation can be found on CIGNA's website at [http://www.cigna.com/sites/healthcare\\_reform/customer.html](http://www.cigna.com/sites/healthcare_reform/customer.html).**

**If your plan is subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.**

**If your plan is a nonfederal government plan or a church plan, you may also contact the U.S. Department of Health and Human Services at [www.healthreform.gov](http://www.healthreform.gov).**

## **Patient Protection and Affordable Care Act Required Notices**

### **Direct Access to Obstetricians and Gynecologists:**

**You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit [www.mycigna.com](http://www.mycigna.com) or contact customer service at the phone number listed on the back of your ID card.**

### **Selection of a Primary Care Provider:**

**Your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, CIGNA may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit [www.mycigna.com](http://www.mycigna.com) or contact customer service at the phone number listed on the back of your ID card.**

**For children, you may designate a pediatrician as the primary care provider.**

BENEFIT INFORMATION	IN-NETWORK	OUT-OF-NETWORK
<b>Calendar Year Plan Deductible</b> <i>Individual / Family Maximum</i>	None/None	\$350 / \$700
<b>Calendar Year Out-of-Pocket Maximum</b> <i>Individual / Family Maximum</i>	<i>Excluding Plan Deductible</i> None/None	<i>Excluding Plan Deductible</i> \$5,000 / \$10,000
<b>Coinsurance</b>	CIGNA HealthCare pays 100% of eligible charges. You pay 0% of charges.	CIGNA HealthCare pays 70% of eligible charges. You pay 30% of charges after plan deductible.
<b>Precertification -Inpatient – PHS (required for all inpatient admissions)</b>	Coordinated by your physician	Participant must obtain approval for inpatient admission; subject to a \$250 per admission penalty for non-compliance.
<b>Lifetime Maximum</b>	Unlimited	Unlimited
<b>Pre-existing Condition Limitation</b>	No	No
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Physician Services</b> <b>Primary Care Physician (PCP) Office Visit</b>	\$25 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.	<b>Your plan pays:</b>  70% of charges**
<b>Specialty Physician Office Visit</b> <i>Consultant and Referral Physician Services</i> <b>Note:</b> A copayment applies for OB/GYN visits. If your doctor is listed as a PCP in the provider directory, you will pay a PCP copayment. If your doctor is listed as a specialist, you will pay the same copayment.	\$25 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.	70% of charges**
<b>Allergy Treatment/Injections - PCP or Specialty Physician</b>	\$25 copayment per office visit or actual charge, whichever is less	70% of charges**
<b>Allergy Serum (dispensed by physician in office)</b>	No charge	70% of charges**
<b>Second Opinion Consultations (provided on voluntary basis)</b>	\$25 copayment per office visit	70% of charges**
<b>Surgery Performed in the Physician's Office- PCP or Specialty Physician</b>	\$25 copayment per office visit	70% of charges**
<b>Preventive Care</b> <i>Routine Preventive Care-Well Baby Care, Well Child Care and Adult Preventive Care</i>	No charge, including when only x-ray and/or lab services are performed and billed.	70% of charges**
<b>Immunizations</b>	No charge	70% of charges**
<b>Mammograms, PSA, Pap Test</b>  <b>Note:</b> Diagnostic related services are paid at the same level of benefits as other x-ray and lab services, based on place of service.	No charge if billed by an independent diagnostic facility of outpatient hospital.  No charge for associated wellness exam	70% of charges**
<b>Inpatient Hospital Services including:</b> <i>Semi-Private Room and Board Diagnostic/Therapeutic Lab and X-ray Drugs and Medication Operating and Recovery Room Radiation Therapy and Chemotherapy Anesthesia and Inhalation Therapy MRIs, MRAs, CAT Scans, PET Scans, etc.</i>	No charge	70% of charges*  Precertification required (Participants must obtain approval for inpatient admission; subject to a \$250 per admission penalty for non-compliance.)
<b>Inpatient Hospital Doctor's Visits/Consultations</b> <i>Inpatient Hospital Professional Services</i>	No charge No charge	70% of charges** 70% of charges**

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Outpatient Facility Services includes:</b> <i>Operating Room, Recovery Room, Procedure Room and Treatment Room and Observation Room including:  Diagnostic/Therapeutic Lab and X-rays  Anesthesia and Inhalation Therapy  Physician &amp; Outpatient Professional Services</i>	No charge  No charge	70% of charges**  70% of charges**
<b>Laboratory &amp; Radiology Services (includes preadmission testing)</b> <i>Physician's Office  Outpatient Hospital Facility   Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit)   Independent X-Ray and/or Lab Facility  Independent X-Ray and/or Lab Facility (in conjunction with an Emergency Room visit)</i>	\$25 copayment per office visit No charge  No charge  No charge No charge	70% of charges** 70% of charges**  No charge  70% of charges** No charge
<b>Advanced Radiological Imaging (MRIs, MRAs, CAT Scans, PET Scans, etc.)</b>  <i>Outpatient Facility   Emergency Room (billed by facility as part of the Emergency Room visit)   Physician's Office</i>	No charge  No charge  No charge	70% of charges**  No charge  70% of charges**
<b>Short-Term Rehabilitative Therapy and Cardiac Rehabilitation --(includes physical therapy, cardiac rehab, speech, occupational, pulmonary rehab &amp; cognitive therapy)</b> 60 days maximum per calendar year# for all therapies combined  <u>Note:</u> therapy sessions provided as part of Home Health Care accumulate to the Short-Term Rehab Therapy maximum.	\$25 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.  \$15 copayment per office visit for Physical Therapy; No charge after office visit copay if only x-ray and/or lab services are performed and billed.	70% of charges**  70% of charges**
<b>Chiropractic Services</b> Unlimited maximum per calendar year	\$15 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.	70% of charges** Maximum allowable amounts will be paid by the Plan up to the approximate average level as to those rendered by an in-network provider.
<b>Emergency and Urgent Care Services</b> <i>Physician's Office – PCP or Specialty Physician   Hospital Emergency Room   Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician)   Urgent Care Facility or Outpatient Facility   Ambulance</i>	\$25 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.  \$50 copayment per visit (copay waived if admitted)  No charge  No charge  No charge	

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><b>Maternity Care Services</b>  <i>Initial Office Visit to Confirm Pregnancy</i>  <b>Note:</b> A copayment applies for OB/GYN visits. If your doctor is listed as a PCP in the provider directory, you will pay a PCP copayment. If your doctor is listed as a specialist, you will pay the same copayment.</p> <p><i>All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee)</i></p> <p><i>Office Visits not included in the total maternity fee performed by OB or Specialty Physician</i></p> <p><i>Delivery - Facility (Inpatient Hospital/Birthing Center Charges)</i></p>	<p>\$25 copayment for initial office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.</p> <p>No charge</p> <p>\$25 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services performed and billed.</p> <p>No charge</p>	<p>70% of charges**</p> <p>70% of charges**</p> <p>70% of charges**</p> <p>70% of charges*, precertification required (Participants must obtain approval for inpatient admission; subject to a \$250 per admission penalty for non-compliance.)</p>
<p><b>Inpatient Services at Other Health Care Facilities</b>  <i>Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities</i>  60 days maximum per calendar year# combined for all facilities listed</p>	<p>No charge</p>	<p>70% of charges**</p>
<p><b>Home Health Services</b> — Includes outpatient private duty nursing when approved as medically necessary  200 days maximum per calendar year#;  16 hour maximum per day#</p>	<p>No charge</p>	<p>75% of charges after a separate \$50.00 deductible has been satisfied**</p>
<p><b>Family Planning Services</b>  <i>Office Visits (lab &amp; radiology tests, counseling)</i></p> <p><b>Vasectomy/Tubal Ligation (excludes reversals)</b>  <i>Inpatient Facility</i></p> <p><i>Outpatient Facility</i></p> <p><i>Physician's Services – Inpatient or Outpatient Physician's Office</i></p>	<p>\$25 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services performed and billed.</p> <p>No charge</p> <p>No charge</p> <p>No charge  \$25 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services performed and billed.</p>	<p>70% of charges**</p> <p>70% of charges*, precertification required (Participants must obtain approval for inpatient admission; subject to a \$250 per admission penalty for non-compliance.)</p> <p>70% of charges**</p> <p>70% of charges**  70% of charges**</p>
<p><b>Infertility Services</b>  <i>Office Visit (lab &amp; radiology tests, counseling)-PCP or Specialty Physician</i></p> <p><b>Treatment/Surgery (includes artificial insemination) (excludes in-vitro fertilization, GIFT, ZIFT, etc.)</b>  <i>Inpatient Facility</i></p> <p><i>Outpatient Facility</i></p> <p><i>Physician's Services - Inpatient or Outpatient</i></p>	<p>\$25 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services performed and billed.</p> <p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>70% of charges**</p> <p>70% of charges*, precertification required (Participants must obtain approval for inpatient admission; subject to a \$250 per admission penalty for non-compliance.)</p> <p>70% of charges**</p> <p>70% of charges**</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><b>TMJ - Surgical and Non-Surgical-case-by-case basis.</b>  <b>Always excludes appliances &amp; orthodontic treatment.</b>  <b>Subject to medical necessity.</b>  <b>Physician's Office</b></p> <p><i>Inpatient Facility</i></p> <p><i>Outpatient Facility</i></p> <p><i>Physician's Services - Inpatient or Outpatient</i></p>	<p>\$25 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services performed and billed.  No charge</p> <p>No charge</p> <p>No charge</p>	<p>70% of charges**</p> <p>70% of charges*, precertification required (Participants must obtain approval for inpatient admission; subject to a \$250 per admission penalty for non-compliance.)</p> <p>70% of charges**</p> <p>70% of charges**</p>
<p><b>Mental Health</b></p> <p><i>Inpatient</i> - 30 days maximum per calendar year#  Acute: Based on a ratio of 1:1  Partial: Based on a ratio of 2:1  Residential: Based on a ratio of 2:1</p> <p><i>Outpatient</i> – 45 visits maximum per calendar year#</p> <p><i>Group Therapy</i> – combined maximum with Outpatient Individual Mental Health services based on a ratio of 2:1</p> <p><i>Intensive Outpatient</i> – up to 3 programs maximum per calendar year # based on a ratio of 1:1 with outpatient Mental Health visits</p>	<p>No charge</p> <p>\$25 copayment per office visit</p> <p>\$25 copayment per session</p> <p>\$50 per program copayment</p>	<p>70% of charges*, precertification required (Participants must obtain approval for inpatient admission; subject to a \$250 per admission penalty for non-compliance.)</p> <p>70% of charges**</p> <p>70% of charges**</p> <p>\$50 per program deductible, plus 70% of charges</p>
<p><b>Substance Abuse</b></p> <p><i>Inpatient</i> - 30 days maximum per calendar year#  Acute Detox: Based on a ratio of 1:1 (requires 24 hour nursing)  Acute Inpatient Rehab: Based on a ratio of 1:1 (requires 24 hour nursing)  Partial: Based on a ratio of 2:1  Residential: Based on a ratio of 2:1</p> <p><i>Outpatient</i> - 60 visits maximum per calendar year#</p> <p><i>Intensive Outpatient Substance Abuse</i> – up to 3 programs maximum per calendar year# based on a ratio of 1:1 with outpatient Substance Abuse visits</p>	<p>No charge</p> <p>\$25 copayment per office visit</p> <p>\$50 per program copayment</p>	<p>70% of charges*, precertification required (Participants must obtain approval for inpatient admission; subject to a \$250 per admission penalty for non-compliance.)</p> <p>70% of charges**</p> <p>\$50 per program deductible, plus 70% of charges</p>
<p><b>Durable Medical Equipment</b>  Unlimited maximum per calendar year</p>	<p>No charge</p>	<p>70% of charges**</p>
<p><b>External Prosthetic Appliances</b>  Unlimited maximum per calendar year</p>	<p>No charge</p>	<p>70% of charges**</p>
<p><b>Wigs</b>  Limit: One wig per lifetime. Covered for loss of hair due to medical condition.</p>	<p>No charge</p>	<p>70% of charges**</p>
<p><b>Acupuncture</b>  Subject to medical necessity review. Treatment will be approved if rendered by a trained acupuncturist for relief of pain, or producing anesthesia.</p>	<p>\$25 copayment per office visit</p>	<p>70% of charges**</p>

*\* Services are subject to calendar year deductible*

*\*\* Out-of-network services are subject to calendar year deductible and maximum reimbursable charge limitations. Providers may bill the member the difference between their billed charge and the maximum reimbursable charge as determined by the benefit plan.*

*# In-network and out-of-network services apply to the same treatment or dollar maximum.*

**Footnotes:**

**Regarding In-Network and Out-of-Network Services:**

- *Once the out-of-pocket maximum is reached, the plan pays 100% of eligible charges for the remainder of the plan year, except for Mental Health and Substance Abuse which continue to be paid at the levels specified.*

**Regarding In-Network Services:**

- *All services must be provided by one of the preferred providers on our list in order to be covered.*

**Regarding Out-of-Network Services:**

- *Your out-of-pocket costs will be higher than with a preferred provider.*
- *All out-of-network hospital admissions must be precertified and are subject to Continued Stay Review (CSR). A penalty applies to admissions which are not precertified. Non-approved admissions/days result in denial of benefits. The precertification penalty or cost of denied benefits does not apply to deductible or out-of-pocket maximum.*

**Case Management**

Coordinated by CIGNA HealthCare. This is a service designed 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.

**Benefit Exclusions.**

Your plan provides for most medically necessary services. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

1. Any service or supply not described as covered in the Covered Expenses section of the plan.
2. Any medical service or device that is not medically necessary.
3. Treatment of an illness or injury which is due to war or care for military service disabilities treatable through governmental services.
4. Any services and supplies for or in connection with experimental, investigational or unproven services.
5. Dental treatment of the teeth, gums or structures directly supporting the teeth, 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.
6. 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.
7. 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.
8. Court ordered treatment or hospitalizations.
9. Infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures. Cryopreservation of donor sperm and eggs are also excluded from coverage. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction.
10. Medical and hospital care and costs for the child of a Dependent, unless this infant child is otherwise eligible under the plan.
11. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance.
12. Consumable medical supplies other than ostomy supplies and urinary catheters.
13. Private hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
14. Artificial aids, including but not limited to hearing aids, semi-implantable hearing devices, audiant bone conductors, bone anchored hearing aids, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and dentures.
15. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
16. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
17. Non-prescription drugs and investigational and experimental drugs, except as provided in the plan.
18. Routine foot care, however, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.
19. Genetic screening or pre-implantation genetic screening.
20. Fees associated with the collection or donation of blood or blood products.
21. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
22. All nutritional supplements and formulae are excluded, except infant formula needed for the treatment of inborn errors of metabolism.
23. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.

**Benefit Exclusions-Continued:**

24. The following services are excluded from coverage regardless of clinical indications: Massage Therapy; Cosmetic Surgery and Therapies; 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; Transsexual Surgery; Non-medical counseling or ancillary services; Assistance in the activities of daily living; Cosmetics; Personal or Comfort Items; Dietary Supplements; Health and Beauty Aids; Aids or devices that assist with non-verbal communications; Treatment by Acupuncture; Dental implants for any condition; Telephone Consultations; E-mail & Internet Consultations; Telemedicine; Health Club Membership fees; Weight Loss Program fees; Smoking Cessation Program fees; Reversal of male and female voluntary sterilization procedures; and Extracorporeal Shock Wave Lithotripsy for musculoskeletal and orthopedic conditions.

**These Are Only the Highlights**

*As you can see, the plan is designed to combine in-depth coverage with cost-effective prices. This summary contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations including legislated benefits are contained in the Summary Plan Description or Insurance Certificate. This plan is insured and/or administered by Connecticut General Life Insurance Company, a CIGNA Company.*

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**Catalog Number: BSM50206 (06/2011)**

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