

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

CIGNA HealthCare Benefit Summary		
Long Island University		
PPO Copay Plan(Active and Retirees Under 65		
Benefit Option = PPO		
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	Unlimited
Coinsurance Levels	100%	80% of Reasonable & Customary Claims paid at 90 th percentile.
Calendar Year Deductible <i>Individual</i> <i>Family Maximum</i>	None None	\$100 per person \$300 per family Combined with Med/RX
Calendar Year Out-of-Pocket Maximum <i>Includes Deductible</i> <i>Includes Copay</i> <i>Individual</i> <i>Does not apply to</i> Benefits for accident or sickness (includes mental health, alcohol and drug abuse benefits) are paid at 100% of charges once an individual's out-of-pocket has been reached.	Not Applicable No \$2,000 per person	No No \$2,000 per person Non-compliance penalties, copays or charges in excess of Reasonable and Customary
Automated Annual Reinstatement Common Accident Multiple Birth 3 Month Carryover	Not Applicable	
Physician's Services <i>Primary Care Physician's Office visit</i> Note: OB/GYN is considered a Specialist <i>Specialty Care Physician's Office Visit</i> <i>Office Visits</i> <i>Consultant and Referral Physician's Services</i> <i>Surgery Performed In the Physician's Office</i> <i>Second Opinion Consultations (services will be provided on a voluntary basis)</i>	No charge after \$10 PCP per office visit copay; No charge after the PCP per visit copay if only x-ray and/or lab services performed and billed. No charge after \$10 Specialist per office visit copay; No charge after the Specialist per visit copay if only x-ray and/or lab services performed and billed. No charge after \$10 per office visit copay No charge after \$10 Specialist per office visit copay	80% after plan deductible 80% after plan deductible 80% after plan deductible 80% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<i>Allergy Treatment/Injections</i>	No charge after either the PCP or Specialist per office visit copay or the actual charge, whichever is less.	80% after plan deductible
<i>Allergy Serum (dispensed by the physician in the office)</i>	No charge	80% after plan deductible
Preventive Care <i>Routine Preventive Care for children birth through age 18 (including immunization)</i>	<u>NY Residents</u> No charge	80% after plan deductible
<i>Routine Adult Preventive Care (Age 19 and above)</i>	<u>All other States:</u> No charge after the PCP or Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only x-ray and/or lab services performed and billed.	80% after plan deductible
Note: Well-woman OB/GYN visits will be subject to the plan's Specialist copay		
Note: x-ray and/or lab services performed and billed by an independent diagnostic facility or outpatient hospital are covered under the plan's x-ray/lab benefit.		
<i>Immunizations</i>	No charge	80% after plan deductible
Mammograms, PSA, Pap Smear	No charge if billed by an independent diagnostic facility or outpatient hospital.	80% after plan deductible
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.		
Inpatient Hospital - Facility Services	No charge	80% after plan deductible
<i>Semi Private Room and Board</i>	Limited to semi-private room negotiated rate	Limited to semi-private room rate
<i>Private Room</i>	Limited to semi-private room negotiated rate	Limited to semi-private room rate
<i>Special Care Units (ICU/CCU)</i>	Limited to negotiated rate	Limited ICU/CCU daily room rate
Inpatient Hospital Physician's Visits/Consultations	No charge	80% after plan deductible
Inpatient Hospital Professional Services	No charge	80% after plan deductible
<i>Surgeon</i>		
<i>Radiologist</i>		
<i>Pathologist</i>		
<i>Anesthesiologist</i>		
Multiple Surgical Reduction	Multiple surgeries performed during one operating session result in payment reduction of 50% of charges to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.	
Outpatient Facility Services <i>Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room</i>	No charge	80% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	No charge	80% after plan deductible
Emergency and Urgent Care Services Physician's Office Hospital Emergency Room Urgent Care Facility or Outpatient Facility Ambulance	No charge after the PCP or Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only x-ray and lab services performed and billed. No charge No charge No charge	No charge after the PCP or Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only x-ray and lab services performed and billed. (except if not a true emergency, then 80% after plan deductible) No charge (except if not a true emergency, then 80% after plan deductible) No charge (except if not a true emergency, then 80% after plan deductible) No charge (except if not a true emergency, then 80% after plan deductible)
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities 100 days combined maximum per calendar year	No charge	80% after plan deductible
Laboratory and Radiology Services (includes pre-admission testing) Advanced Radiological Imaging (i.e. MRI's, CAT Scans and PET Scans) Other Laboratory and Radiology Services Physician's Office Outpatient Hospital Facility Independent X-ray and/or Lab facility	No charge No charge after PCP or Specialist per visit copay No charge No charge	80% after plan deductible 80% after plan deductible 80% after plan deductible 80% after plan deductible
Outpatient Short-Term Rehabilitative Therapy Unlimited days combined maximum per calendar year Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy	No charge after PCP or Specialist per office visit copay Note: Outpatient Short Term Rehab copay applies, regardless of place of service, including the home.	80% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Chiropractic Services</p> <p>Unlimited visits combined maximum per calendar year</p> <p>Separate benefit, NY State Mandate</p>	<p>No charge after PCP or Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only x-ray and/or lab services are performed and billed.</p>	<p>80% after plan deductible</p>
<p>Home Health Care</p> <p>120 days maximum per calendar year (includes outpatient private duty nursing when approved as medically necessary)</p> <p>Note: The maximum number of hours per day is limited to 16 hours. Multiple visits can occur in one day; with a visit defined as a period of 2 hours or less (e.g. maximum of 8 visits per day).</p>	<p>No charge</p>	<p>80% after \$50 maximum deductible</p> <p>Plan deductible waived. NY State Mandate</p>
<p>Hospice</p> <p><i>Inpatient Services</i></p> <p><i>Outpatient Services</i></p>	<p>No charge</p> <p>No charge</p>	<p>80% after plan deductible</p> <p>80% after plan deductible</p>
<p>Bereavement Counseling</p> <p><i>Services provided as part of Hospice Care</i></p> <p><i>Inpatient (same coinsurance level as Inpatient Hospice Facility)</i></p> <p><i>Outpatient (same coinsurance level as Outpatient Hospice)</i></p> <p><i>Services provided by Mental Health Professional</i></p>	<p>No charge</p> <p>No charge</p> <p>Covered under Mental Health benefit</p>	<p>80% after plan deductible</p> <p>80% after plan deductible</p> <p>80% after plan deductible</p>
<p>Maternity Care Services</p> <p><i>Initial Visit to Confirm Pregnancy</i></p> <p>Note: OB/GYN provider is considered a Specialist</p> <p><i>All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges (i.e. global maternity fee)</i></p> <p><i>Office Visits in addition to the global maternity fee when performed by an OB or Specialist</i></p> <p><i>Delivery – Facility (Inpatient Hospital, Birthing Center)</i></p>	<p>No charge after the PCP or Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only x-ray and/or lab services are performed and billed.</p> <p>No charge</p> <p>No charge after the PCP or Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only x-ray and/or lab services are performed and billed.</p> <p>No charge</p>	<p>80% after plan deductible</p> <p>80% after plan deductible</p> <p>80% after plan deductible</p> <p>80% after plan deductible</p>
<p>Abortion</p> <p><i>Includes elective and non-elective procedures</i></p> <p><i>Inpatient Facility</i></p> <p><i>Outpatient Surgical Facility</i></p> <p><i>Physician's Office</i></p>	<p>No charge</p> <p>No charge</p> <p>No charge after \$10 per office visit copay</p>	<p>80% after plan deductible</p> <p>80% after plan deductible</p> <p>80% after plan deductible</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
External Prosthetic Appliances Unlimited maximum per calendar year	No charge	80% after plan deductible
Dental Care <i>Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.</i> <i>Doctor's Office</i> <i>Inpatient Facility</i> <i>Outpatient Surgical Facility</i> <i>Physician's Services</i>	No charge after the PCP or Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only x-ray and/or lab services are performed and billed. No charge No charge No charge	80% after plan deductible 80% after plan deductible 80% after plan deductible 80% after plan deductible
TMJ – Surgical and Non-Surgical NY State Mandate (covered with medical necessity case specifically; excludes appliances and orthodontic treatment): Doctor's Office Inpatient Facility Outpatient Surgical Facility Physician's Services	No charge after the PCP or Specialist per office visit copay No charge No charge No charge	80% after plan deductible 80% after plan deductible 80% after plan deductible 80% after plan deductible
Obesity/Bariatric Surgery NY State Mandate (Covered when medically necessary based on state requirements) <i>Doctor's Office</i> <i>Inpatient Facility</i> <i>Outpatient Facility</i> <i>Physician's Services</i>	Note: Coverage is provided subject to medical necessity and clinical guidelines. Note: Covered only at approved centers through the pre-certification process. No charge after PCP or Specialist office visit copay; No charge if only x-ray and/or lab services performed and billed. No charge No charge No charge	80% after plan deductible 80% after plan deductible 80% after plan deductible 80% after plan deductible
Routine Foot Disorders When medically necessary.	No charge	80% after plan deductible
Acupuncture	No charge after PCP or Specialist office visit copay	80% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Prescription Drugs CIGNA Pharmacy Retail Drug Program</p> <p><i>No Mandatory Generic, No Prior Authorization Edits Open Prescription Drug List (Clinical Mgmt None, Injectables & Lifestyle no PA's)</i></p> <p><i>Includes: Self administered injectables, oral contraceptives, oral fertility drugs, contraceptive devices, insulin items (including insulin) prenatal vitamins, optional indictable and lifestyle drugs (No PA's) Prescription Vitamins, (covers Periostat/Periogard/Peridex)</i></p> <p><i>Excludes: Injectable infertility drugs, buy-up injectable drugs, fluoride preps, smoking cessation, and anti- obesity drugs.</i></p>	<p>80% after deductible per 30-day supply for prescription drugs</p>	<p>80% after deductible</p>
<p>Pharmacy Out of Pocket Maximum (retail only)</p>	<p>: Combined Med/RX</p>	<p>Combined Med/RX</p>
<p>CIGNA Tel-Drug Mail Order Drug Program</p> <p><i>No Mandatory Generic, Open Prescription Drug List (Clinical Mgmt None, Injectables & Lifestyle no PA's)</i></p> <p><i>Includes: Self administered injectables, oral contraceptives, oral fertility drugs, contraceptive devices, insulin items (including insulin) prenatal vitamins, optional indictable and lifestyle drugs (No PA's) Prescription Vitamins, (covers Periostat/Periogard/Peridex)</i></p> <p><i>Excludes: Injectable infertility drugs, buy-up injectable drugs, fluoride preps, smoking cessation, and anti- obesity drugs.</i></p>	<p>80% no deductible per 90-day supply for prescription drugs</p>	

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Mental Health</p> <p><i>Inpatient</i> 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></p> <p><i>Outpatient Group Therapy</i> Subject to the plan's outpatient Mental Health benefit maximum based on a 1:1 ratio</p> <p><i>Intensive Outpatient Mental Health</i></p> <p>Maximum: Up to 3 programs per calendar year Based on ratio of 1:1</p>	<p>No charge 30 days combined maximum per calendar year</p> <p>No charge after \$10 per visit copay; 30 visits combined maximum per calendar year No charge after \$10 per visit copay</p> <p>Single copay per program</p> <p>100% after \$30 per program copay Note: The Intensive Outpatient per program copay will be taken prior to any payment</p>	<p>80% after plan deductible; 30 days combined maximum per calendar year</p> <p>80% after plan deductible; 30 visits combined maximum per calendar year</p> <p>Subject to the same coinsurance level and plan deductible as Outpatient MH visits</p> <p>80% after plan deductible</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><i>Substance Abuse</i> <i>Inpatient</i></p> <p>Acute Detox: Requires 24 hour nursing; Based on a ratio of 1:1 Acute Inpatient Rehab: Requires 24 hour nursing; 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></p> <p><i>Intensive Outpatient (alcohol & drug)</i> Maximum: Up to 3 programs per calendar year Based on ratio of 1:1</p>	<p>No charge 30 days combined maximum per calendar year</p> <p>No charge after \$10 per visit copay; 60 visits combined maximum per calendar year</p> <p>Single copay per program</p> <p>100% after \$30 per program copay Note: The Intensive Outpatient per program copay will be taken prior to any payment</p>	<p>80% after plan deductible 30 days combined maximum per calendar year</p> <p>80% after plan deductible; 60 visits combined maximum per calendar year</p> <p>80% NO plan deductible</p>
<p><i>MH/SA Service Specific Administration</i></p>	<p>Partial Hospitalization, Residential Treatment and Intensive Outpatient Programs:</p> <p>The following administration will apply:</p> <ul style="list-style-type: none"> • Partial Hospitalization: MH and/or SA partial hospitalization services maximum is 50% of the inpatient benefit maximum; e.g. day limits are combined (2:1 ratio). The coinsurance level for partial hospitalization services is the same as the coinsurance level for inpatient MH/SA services. • Standard Option for Residential Treatment: MH and/or SA Residential Treatment at 50% of Inpatient benefit; day limits are combined (2:1 ratio). Coverage only if approved through CBH Case Management. • Intensive Outpatient Program (IOP): MH and/or SA Intensive Outpatient Program at 1 to 1 Outpatient visits. Visit limits are combined with Outpatient Visit limits (1:1 ratio). Coverage only if approved through CBH Case Management. 	
<p><i>MH/SA Utilization Review & Case Management</i></p>	<p>CBH provides utilization review and case management for Inpatient Services</p>	
<p><i>Pre-existing Condition Limitation (PCL)</i></p>	<p>NONE</p>	

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><i>Pre-Admission Certification - Continued Stay Review</i></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> <p><i>PHS</i></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"> - 50% penalty applied to hospital inpatient charges for failure to contact CIGNA Healthcare to precertify admission. - 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.
<p><i>Case Management</i></p>	<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>	

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; Orthognathic Surgeries; 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. 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.
11. 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.
12. 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."
13. Infertility services, 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, and any 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.
14. Reversal of male and female voluntary sterilization procedures.
15. Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
16. 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.



17. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
18. 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.
19. 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.
20. 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."
21. Private hospital rooms and/or private duty nursing except as provided in the Home Health Services section of "Section IV. Covered Services and Supplies".
22. 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.
23. Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
24. Hearing aids, 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.
25. 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.
26. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
27. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
28. 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."
29. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
30. 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.
31. Dental implants for any condition.
32. 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.
33. Blood administration for the purpose of general improvement in physical condition.
34. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
35. Cosmetics, dietary supplements and health and beauty aids.
36. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
37. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
38. Telephone, e-mail & Internet consultations and telemedicine.
39. 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.

“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.