

SUMMARY OF BENEFITS

Your **CIGNA Choice FundSM**

Health Savings Account-Open Access Plus plan



Features that Add Value

- **CIGNA Choice Fund** combines conventional health coverage with a savings account and other investment options to help you pay for the cost of your health care services. See the next page for more information.
- 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 LineSM 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.
- **CIGNA Healthy Rewards[®]** 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.
- 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.

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 LanguagesSM**. 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.
- CIGNA Well Aware for Better Health[®] can **help you manage** certain chronic conditions.
- The CIGNA HealthCare Healthy Babies[®] 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 participating 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 and lower 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 higher when you see "participating provider," 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 Employees of Vernon Board of Education (Nurses)

HOW YOUR CIGNA CHOICE FUND HEALTH SAVINGS ACCOUNT WORKS

This product combines traditional medical coverage with a savings account and investment options. You can make tax-free contributions to the savings account up to federal limits.

For 2010, your annual contribution is limited up to \$3,050 for individuals and up to \$6,150 for families. Limits for future years will be set by the IRS.

If you are age 55 or older, and not enrolled in Medicare, you may make an additional contribution of up to \$1,000 to your HSA in 2009 and later years until you are age 65 and are enrolled in Medicare. Please consult with your tax advisor for further information.

Maximum contributions are based upon maintaining enrollment in a qualified HSA medical plan on the 1st of the month for 12 months of the contract year. For enrollment less than 12 months during a contract year, you may not be eligible for the maximum contribution for the contract year. Please consult your tax advisor.

HSA dollars can be used to reimburse yourself for qualified healthcare expenses incurred by you, your spouse or eligible dependents. Qualified expenses include medical, dental and vision expenses as defined under Section 213(d) of the tax code and include expenses that are not covered by your HSA qualified medical plan. Qualified dependents are children, siblings, parents and others who are considered an exemption under Section 152 of the tax code.

Any dollars remaining in your savings account at the end of the year carry over to the next year. If you change employers or retire, you may take any dollars in your savings account with you.

The plan deductible is the portion of covered medical and pharmacy expenses that you pay before your plan will begin to cover healthcare expenses. Only covered services count toward the plan deductible. Once your plan deductible has been met, your plan begins providing coverage for eligible services as described below. All covered expenses (including those expenses applied to the plan deductible) benefit from CIGNA HealthCare negotiated discounts with participating providers and pharmacies.

You can choose how you pay for medical expenses that are submitted through your qualified HSA medical plan.

- ❖ You may pay for medical expenses on a claim-by-claim basis using the debit card, online bill pay feature, or a checkbook that is available upon request.
- ❖ You may choose the auto claim forwarding feature, where your qualified out-of-pocket costs are paid directly from your savings account by CIGNA HealthCare. (*Note* that the auto claim forwarding feature is not available for pharmacy expenses and in most situations is not available to mental health and substance abuse claims. To access HSA funds for these expenses, you will need to use your HSA debit card or HSA account checks.)
- ❖ You may choose to cover your expenses using your own personal funds. This allows you to save your HSA dollars for future years.

Health Savings Account	Employee	Employee + One	Employee + Family
<i>Employer Contribution</i>	\$1,000	\$2,000	\$2,000

KEY BENEFIT INFORMATION	IN-NETWORK	OUT-OF-NETWORK
Plan Contract Year Deductible – Collective (combined Medical and Pharmacy) Individual (Employee Only – no covered dependents) Family Maximum – (Employee + Family)	<i>Deductible Maximums cross-accumulate</i> \$1,500 \$3,000	<i>Deductible Maximums cross-accumulate</i> \$1,500 \$3,000
Family Collective Deductible: All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.		
Plan Contract Year Out-of-Pocket Maximum – Collective (combined Medical and Pharmacy) Individual (Employee Only – no covered dependents) Family Maximum (Employee + Family)	<i>Out-of-Pocket Maximums cross-accumulate</i> \$1,500 Including Plan Deductible \$3,000 Including Plan Deductible	<i>Out-of-Pocket Maximums cross-accumulate</i> \$3,000 Including Plan Deductible \$6,000 Including Plan Deductible
Family Collective Out-of-Pocket Maximum: All family members contribute towards the family out-of-pocket maximum. An individual cannot have claims covered at 100% until the total family out-of-pocket maximum has been satisfied.		
Coinsurance	CIGNA HealthCare pays 100% of eligible charges. You pay 0% of charges after plan deductible.	CIGNA HealthCare pays 70% of eligible charges. You pay 30% of charges after plan deductible.
Inpatient Preadmission Certification-CSR - PHS (required for all inpatient admissions)	Coordinated by your physician	Participant must obtain approval for inpatient admission ; subject to penalty/reduction or denial for non-compliance
Lifetime Maximum <i>Note: In addition to the combined medical and pharmacy deductible and out-of-pocket maximum, the plan's lifetime maximum will also be combined</i>	Unlimited	Unlimited
Pre-existing Condition Limitation	No	No
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician Services Primary Care Physician (PCP) Office Visit	No charge after plan deductible*; No charge after plan deductible* if only x-ray and/or lab services are performed and billed.	30% of charges**
Specialty Physician Office Visit <i>Consultant and Referral Physician Services</i>	No charge after plan deductible*; No charge after plan deductible* if only x-ray and/or lab services are performed and billed.	30% of charges**
Allergy Treatment/Injections - PCP or Specialty Physician	No charge after plan deductible*	30% of charges**
Allergy Serum (dispensed by physician in office)	No charge after plan deductible*	30% of charges**
Second Opinion Consultations (provided on voluntary basis)	No charge after plan deductible*	30% of charges**
Surgery Performed in the Physician's Office- PCP or Specialty Physician	No charge after plan deductible*	30% of charges**
Preventive Care Routine Preventive Care – Well Baby Care, Well Child Care and Adult Preventive Care ^{AAA} Unlimited maximum per contract year	No charge, no plan deductible; No charge, no plan deductible, for x-ray and/or lab services when billed by a separate outpatient diagnostic facility.	30% of charges**
Immunizations (including travel immunizations)	No charge, no plan deductible	30% of charges**
Mammograms, PSA, Pap Test <i>Diagnostic Mammograms, PSA, Pap Test</i>	No charge, no plan deductible No charge after plan deductible*	30% of charges** 30% of charges**

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital Services including: 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	No charge after plan deductible*	30% of charges* per admission Precertification required
Inpatient Hospital Doctor's Visits/Consultations Inpatient Hospital Professional Services	No charge after plan deductible* No charge after plan deductible*	30% of charges** 30% of charges**
Outpatient Facility Services includes: Operating Room, Recovery Room, Procedure Room and Treatment Room and Observation Room including: Diagnostic/Therapeutic Lab and X-rays Anesthesia and Inhalation Therapy	No charge after plan deductible*	30% of charges**
Physician & Outpatient Professional Services	No charge after plan deductible*	30% of charges**
Laboratory and Radiology Services (includes preadmission testing) 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)	No charge after plan deductible* No charge after plan deductible* No charge after plan deductible* No charge after plan deductible* No charge after plan deductible*	30% of charges** 30% of charges** No charge after plan deductible*; except if not a true emergency, then 30% of charges** 30% of charges** No charge after plan deductible*; except if not a true emergency, then 30% of charges**
Advanced Radiological Imaging (MRIs, MRAs, CAT Scans, PET Scans, etc.) Outpatient Facility Emergency Room (billed by facility as part of the Emergency Room visit) Physician's Office	No charge after plan deductible* No charge after plan deductible* No charge after plan deductible*	30% of charges** No charge after plan deductible*; except if not a true emergency, then 30% of charges** 30% of charges**
Short-Term Rehabilitative Therapy and Chiropractic Services--(includes physical, speech, occupational, chiropractic, pulmonary rehab & cognitive therapy) Unlimited maximum per contract 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. Outpatient Cardiac Rehabilitation Unlimited maximum per contract year	No charge after plan deductible*; No charge after plan deductible* if only x-ray and/or lab services are performed and billed. No charge after plan deductible*	30% of charges** 30% of charges**
Other Therapy Services Radiation Therapy Chemotherapy for the treatment of cancer Electroshock Therapy Kidney Dialysis in a hospital or free-standing dialysis center Unlimited maximum per calendar year	No charge after plan deductible*; No charge after plan deductible* if only x-ray and/or lab services are performed and billed.	30% of charges**

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Emergency and Urgent Care Services <i>Physician's Office – PCP or Specialty Physician</i></p> <p><i>Hospital Emergency Room</i></p> <p><i>Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician)</i></p> <p><i>Urgent Care Facility or Outpatient Facility</i></p> <p><i>Ambulance</i></p>	<p>No charge after plan deductible*; No charge after plan deductible* if only x-ray and/or lab services are performed and billed.</p> <p>No charge after plan deductible*</p> <p>No charge after plan deductible*</p> <p>No charge after plan deductible*</p> <p>No charge after plan deductible*</p>	<p>No charge after plan deductible*; No charge after plan deductible* if only x-ray and/or lab services are performed and billed.</p> <p>No charge after plan deductible* per visit</p> <p>No charge after plan deductible* per visit</p> <p>No charge after plan deductible*</p> <p>No charge after plan deductible*</p>
<p>Maternity Care Services <i>Initial Office Visit to Confirm Pregnancy</i></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>No charge after plan deductible*; No charge after plan deductible* if only x-ray and/or lab services are performed and billed</p> <p>No charge after plan deductible*</p> <p>No charge after plan deductible*; No charge after plan deductible* if only x-ray and/or lab services are performed and billed.</p> <p>No charge after plan deductible*</p>	<p>30% of charges**</p> <p>30% of charges**</p> <p>30% of charges**</p> <p>30% of charges*, precertification required</p>
<p>Inpatient Services at Other Health Care Facilities <i>Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities - 220 days maximum per contract year# combined for all facilities listed</i></p>	<p>No charge after plan deductible*</p>	<p>30% of charges**</p>
<p>Home Health Services – <i>Includes outpatient private duty nursing when approved as medically necessary</i> Unlimited maximum per contract year; 16 hour maximum per day#</p>	<p>No charge after plan deductible*</p>	<p>30% of charges**</p>
<p>Family Planning Services <i>Office Visits (lab & radiology tests, counseling)</i></p> <p>Vasectomy/Tubal Ligation (excludes reversals) <i>Inpatient Facility</i> <i>Outpatient Facility</i> <i>Physician's Services – Inpatient or Outpatient</i> <i>Physician's Office</i></p>	<p>No charge after plan deductible*; No charge after plan deductible* if only x-ray and/or lab services are performed and billed.</p> <p>No charge after plan deductible*</p> <p>No charge after plan deductible*</p> <p>No charge after plan deductible*</p> <p>No charge after plan deductible*; No charge after plan deductible* if only x-ray and/or lab services are performed and billed</p>	<p>30% of charges**</p> <p>30% of charges*, precertification required</p> <p>30% of charges**</p> <p>30% of charges**</p> <p>30% of charges**</p>
<p>Infertility Services <i>Office Visit (lab & radiology tests, counseling)-PCP or Specialty Physician</i></p> <p>Treatment/Surgery (includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.); subject to the following maximums: <i>Four cycles of ovulation induction per lifetime.</i> <i>Three cycles of intrauterine insemination per lifetime.</i> <i>Two cycles of low tubal ovum transfer, IVF, GIFT and/or ZIFT per lifetime, with not more than two transfers per cycle.</i></p> <p><i>Inpatient Facility</i></p> <p><i>Outpatient Facility</i></p> <p><i>Physician's Services - Inpatient or Outpatient</i></p>	<p>No charge after plan deductible* per office visit; No charge after plan deductible* if only x-ray and/or lab services are performed and billed.</p> <p>No charge after plan deductible*</p> <p>No charge after plan deductible*</p> <p>No charge after plan deductible*</p>	<p>30% of charges**</p> <p>30% of charges*, precertification required</p> <p>30% of charges**</p> <p>30% of charges**</p>
<p>TMJ - Surgical and Non-Surgical</p>	<p>Not covered</p>	<p>Not covered</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Obesity/Bariatric Surgery. Unlimited maximum per contract year <i>Physician's Office</i> <i>Inpatient Facility</i> <i>Outpatient Facility</i> <i>Physician's Services</i>	No charge after plan deductible*; No charge after plan deductible* if only x-ray and/or lab services performed and billed. No charge after plan deductible* No charge after plan deductible* No charge after plan deductible*	30% of charges** 30% of charges*, precertification required 30% of charges** 30% of charges**
Mental Health Inpatient – Unlimited maximum per contract year Outpatient Mental Health (includes Individual, Group Therapy and Intensive Outpatient services) – Unlimited maximum per contract year <i>Physician's Office</i> <i>Outpatient Facility services</i>	No charge after plan deductible* No charge after plan deductible* No charge after plan deductible*	30% of charges*, precertification required 30% of charges** 30% of charges**
Substance Abuse Inpatient – Unlimited maximum per contract year Outpatient Substance Abuse (includes Individual and Intensive Outpatient services) – Unlimited maximum per contract year <i>Physician's Office</i> <i>Outpatient Facility services</i>	No charge after plan deductible* No charge after plan deductible* No charge after plan deductible*	30% of charges*, precertification required 30% of charges** 30% of charges**
Durable Medical Equipment Unlimited maximum per contract year	No charge after plan deductible*	30% of charges**
External Prosthetic Appliances Unlimited maximum per contract year Ostomy Related Services	No charge after plan deductible* No charge after plan deductible*	30% of charges** 30% of charges**
Hearing Aids for Children – age 12 and younger \$1,000 maximum in 24-month period#	No charge after plan deductible*	30% of charges**
Wigs (prescribed for hair loss as a result of chemotherapy) \$500 maximum per calendar year#	No charge after plan deductible*	30% of charges**

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Prescription Drugs-		
<u>CIGNA Pharmacy Retail Drug Program</u>		
Generic drugs for a 34-day supply per prescription/refill	\$10 copayment after plan deductible* per prescription/refill	30% of charges after plan deductible**
Preferred Brand Name drugs for a 34-day supply per prescription/refill	\$20 copayment after plan deductible* per prescription/refill	30% of charges after plan deductible**
Non-Preferred Brand Name drugs for a 34-day supply per prescription/refill	\$30 copayment after plan deductible* per prescription/refill	30% of charges after plan deductible**
<u>CIGNA Home Delivery Pharmacy Program</u>		
Generic drugs for a 100-day supply per prescription/refill	\$20 copayment after plan deductible* per prescription/refill	30% of charges after plan deductible**
Preferred Brand Name drugs for a 100-day supply per prescription/refill	\$40 copayment after plan deductible* per prescription/refill	30% of charges after plan deductible**
Non-Preferred Brand Name drugs for a 100-day supply per prescription/refill	\$60 copayment after plan deductible* per prescription/refill	30% of charges after plan deductible**

* Services are subject to contract year deductible

** Out-of-network services are subject to contract 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 plan's out-of-pocket maximum is reached, the plan pays 100% of eligible charges for the remainder of the plan year, including Mental Health and Substance Abuse services.

Regarding In-Network Services:

- All services must be provided by one of the participating provider 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.

These are examples of the exclusions in your plan. 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.

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. Treatment of TMJ disorder, however medically necessary treatment for craniofacial disorders is covered.
6. 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.
7. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute (NHLBI) guideline is covered only at approved centers if the services are demonstrated, through existing peer-reviewed, evidence-based, scientific literature and scientifically based guidelines, to be safe and effective for treatment of the condition. Clinically severe obesity is defined by the NHLBI as a BMI of 40 or greater without comorbidities, or 35-39 with comorbidities. The following are specifically excluded: 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.
8. 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.
9. Court ordered treatment or hospitalizations.
10. Infertility donor services and charges.
11. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction.
12. Medical and hospital care and costs for the child of a Dependent, unless this infant child is otherwise eligible under the plan.
13. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance.
14. Consumable medical supplies other medically necessary appliances and supplies such as collection devices, irrigation equipment and supplies, skin barriers and skin protectors which are related to an ostomy, colostomy, ileostomy or urostomy surgery and urinary catheters.
15. Private hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
16. Artificial aids, including but not limited to hearing aids for insureds age 13 years of age or older, semi-implantable hearing devices, audiant bone conductors, bone anchored hearing aids, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs (other than wigs prescribed by an oncologist for an insured being treated for cancer)
17. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
18. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
19. Non-prescription drugs and investigational and experimental drugs, except as provided in the plan.
20. Routine foot care, however, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.
21. Genetic screening or pre-implantation genetic screening.
22. Fees associated with the collection or donation of blood or blood products.
23. Cost of biologicals that are immunizations or medications to protect against occupational hazards and risks.
24. All nutritional supplements and formulae are excluded, except infant formula needed for the treatment of inborn errors of metabolism or cystic fibrosis, and medically necessary specialized infant formulas.
25. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
26. The following services are excluded from coverage regardless of clinical indications: 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 affordable 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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