This is a summary of benefits for your Open Access Plus Copay plan. All deductibles and plan out-of-pocket maximums cross accumulate between in-network and out-of network 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

Consolidated Edison Inc.

Open Access Plus Copay Plan – 2021 CECONY Retirees U65 (MGTR and WKLYR)

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Hospital and Medical Combined Lifetime Maximum	Unlimited	
Maximum Reimbursable Charge	N/A	90th Percentile
Coinsurance Levels *Hospital* *Medical*	 100% 90%	 70% 70%
Deductible Accumulators	Cross accumulation between In and Out-of-network	
Calendar Year Hospital Deductible *(1/2 of Medicare Part A deductible)* *Individual*	 $742 (subject to change annually)	 $742 (subject to change annually)
Calendar Year Plan Deductible *Individual* *Family Maximum* *Family Maximum Deductible Calculation* *Copays do not apply* *Carry Over (Oct., Nov. and Dec.)*	 $375 per person $1,025 per family Individual Deductible N/A	 $900 per person $2,600 per family Individual Deductible Yes
Out-of-Pocket Medical Maximum (Includes plan deductible, but not hospital deductible or copays) *Individual* *Family Maximum* *Family Maximum OOP Calculation*	 $1,000 $2,800 Individual OOP	 $3,500 per person N/A Individual OOP
Physician's Services *Physician's Office visit*	100% after $30 PCP or $40 Specialist per office visit copay; 100% after PCP or Specialist per office visit copay if only x-ray and/or lab services performed and billed.	70% after deductible
Second Surgical Opinion	100% no copay	70% after deductible
Allergy Serum and Injections (not in conjunction with an Office visit)	100% no deductible	70% after deductible
Office Surgery	100% no copay if only surgery is only procedure billed.	70% after deductible

	Affiliated Physicians	CIGNA	Out of Network
Preventive Care *Routine Preventive Care for children through age 23*	Not Applicable	100% no copay	100% no deductible
Immunizations including Shingles	Not Applicable, except Shingles, 100%	100% no copay	100% no deductible
Adult Routine Preventive Care Including Immunizations	100% no deductible, no copay	100% no deductible, no copay	Not Covered
Shingles Vaccine and H1N1	100% no deductible	100% no deductible	100% no deductible
Routine Mammograms, PSA, Pap Smear	100% no deductible	100% no deductible	100% no deductible
Well Woman Exam	100% no copay	100% no deductible	100% no deductible

	IN-NETWORK	OUT-OF-NETWORK
Diagnostic Mammograms, PSA, Pap Smear	100% no deductible	70% after deductible
Hearing Exams	100% after Specialist per office visit copay	70% after deductible
Hearing Aids - Up to a $600 lifetime maximum	100% after deductible	100% after deductible
Cochlear Implants – Unlimited lifetime maximum	90% after deductible	70% after deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital - Facility Services	$742 (subject to change annually) then 100% Precertification required	$742 (subject to change annually) then 70% Precertification required
Semi Private Room and Board	Limited to semi-private room negotiated rate	Limited to semi-private room rate
Private Room	Limited to semi-private room negotiated rate	Limited to semi-private room rate
Special Care Units (ICU/CCU)	Limited to negotiated rate	Limited ICU/CCU daily room rate
Outpatient Facility Services *Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room* ***Note:*** *Non-surgical treatment procedures are not subject to the facility copay.*	100% no deductible	100% no deductible
Inpatient Hospital Physician's Visits/Consultations	100% no deductible	70% after deductible
Inpatient Hospital Professional Services *Radiologist; Pathologist; Anesthesiologist* *Surgeons*	100% no deductible	70% after deductible
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 Professional Services		
Radiologist; Pathologist; Anesthesiologist	100% no deductible	100% no deductible
Surgeons	100% no deductible	100% no deductible
Emergency and Urgent Care Services		
Physician's Office	100% after PCP or Specialist per office visit copay; 100% after PCP or Specialist per office visit copay if only x-ray and lab services performed and billed	100% after PCP or Specialist per office visit copay; 100% after PCP or Specialist per office visit copay if only x-ray and lab services performed and billed
Hospital Emergency Room *Copay waived if admitted*	100% after $125 ER copay	100% after $125 ER copay
Outpatient Professional services (radiology, pathology and ER Physician)	100% after deductible	100% after deductible
Urgent Care Facility or Outpatient Facility	100% after $35 Urgent Care copay	100% after $35 Urgent Care copay
Ambulance	90% after deductible	90% after deductible
Inpatient Services at Other Health Care Facilities *Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities*	$742 (subject to change annually) then 100%	$742 (subject to change annually) then 70%
Laboratory and Radiology Services (includes pre-admission testing)		
Physician's Office	100% after $30 PCP or $40 Specialist per office visit copay; 100%, no copay, if only x-ray and/or lab services performed and billed.	70% after deductible
Outpatient Hospital Facility	90% after deductible	70% after deductible
Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	90% after deductible	90% after deductible
Independent X-ray and/or Lab facility	90% after deductible	70% after deductible
Independent X-ray and/or Lab Facility in conjunction with an ER visit	100% after deductible	100% after deductible
Advanced Radiological Imaging (i.e. MRI's, MRAs, CAT Scans and PET Scans, etc.)		
Inpatient Facility	$742 (subject to change annually) then 100% Precertification required	$742 (subject to change annually) then 70% Precertification required
Independent Facility	90% after deductible	70% after deductible
Emergency Room/Urgent Care Facility (billed by the facility as part of the ER visit)	90% after deductible	90% after deductible
Physician's Office	100%	70% after deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Short-Term Rehabilitative Therapy and Cardiac Rehabilitation *Includes:* *Cardiac Rehab – Unlimited maximum per calendar year* *Physical Therapy – Up to a 30 day maximum per calendar year* *Speech Therapy - Up to a 30 day maximum per calendar year* *Occupational Therapy - Up to a 30 day maximum per calendar year* *Pulmonary Rehab - Unlimited maximum per calendar year* *Cognitive Therapy - Unlimited maximum per calendar year* *Acupuncture - Unlimited maximum per calendar year*	90% after deductible .	70% after deductible
Chiropractic Services- *Unlimited maximum per calendar year* *(reviewed for medical necessity*	90% after deductible	70% after deductible
Home Health Care – *Up to 200 day maximum per calendar year* ***Private Duty Nursing –*** *Unlimited maximum.* ***Custodial care is not covered***	90% after deductible	70% after deductible
Hospice *Inpatient Services* *Outpatient Services*	$742 (subject to change annually) then 100% 100% no deductible	$742 (subject to change annually) then 70% 70% after deductible
Bereavement Counseling *Services provided as part of Hospice Care* *Inpatient* *Outpatient* *Services provided by Mental Health Professional*	 $742 (subject to change annually) then 100% 100% no deductible	 $742 (subject to change annually) then 70% 70% after deductible
Maternity Care Services *Initial Visit to Confirm Pregnancy* ***Note:*** *OB/GYN provider is considered a Specialist*	 100% after PCP or Specialist per office visit copay; 100% after PCP or Specialist per office visit copay if only x-ray and/or lab services are performed and billed	 70% after deductible
All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges (i.e. global maternity fee)	90% after deductible	70% after deductible
Office Visits in addition to the global maternity fee when performed by an OB or Specialist	100% after PCP or Specialist per office visit copay; 100% after PCP or Specialist per office visit copay if only x-ray and/or lab services are performed and billed	70% after deductible
Delivery – Facility (Inpatient Hospital, Birthing Center)	$742 (subject to change annually) then 100% Precertification required	$742 (subject to change annually) then 70% Precertification required

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
All Women Family Planning		
Office Visits, Lab and Radiology Tests and Counseling *Maximum: Not subject to plan's Preventive Care dollar maximum*	**CSN/Affiliated Physician**: 100%, no deductible, no copay **Cigna INN**: 100%, no deductible, no copay	70% after deductible
Note: *The standard benefit will include coverage for contraceptive devices when services are provided in the physician's office.*		
Surgical Sterilization Procedure for Tubal Ligation (excludes reversals)		
Inpatient Facility	**CSN/Affiliated Physician**: 100%, no deductible, no copay **Cigna INN**: 100%, no deductible, no copay Precertification required	$742 (subject to change annually) then 70% Precertification required
Outpatient Facility	**CSN/Affiliated Physician**: 100%, no deductible, no copay **Cigna INN**: 100%, no deductible, no copay	100% no deductible
Inpatient Physician's Services	**CSN/Affiliated Physician**: 100%, no deductible, no copay **Cigna INN**: 100%, no deductible, no copay	70% after deductible
Outpatient Physician's Services	**CSN/Affiliated Physician**: 100%, no deductible, no copay **Cigna INN**: 100%, no deductible, no copay	70% after deductible
Physician's Office	**CSN/Affiliated Physician**: 100%, no deductible, no copay **Cigna INN**: 100%, no deductible, no copay	70% after deductible
Family Planning Services (Men's Services)		
Office Visits, Lab and Radiology Tests and Counseling *Maximum: Not subject to plan's Preventive Care dollar maximum* ***Note:*** *The standard benefit will include coverage for contraceptive devices when services are provided in the physician's office.*	100% after PCP or Specialist per office visit copay; 100% after PCP or Specialist per office visit copay if only x-ray and/or lab services are performed and billed	70% after deductible
Surgical Sterilization Procedure for Vasectomy (excludes reversals)		
Inpatient Facility	$742 (subject to change annually) then 100% Precertification required	$742 (subject to change annually) then 70% Precertification required
Outpatient Facility	100% no deductible	100% no deductible
Inpatient Physician's Services	100% no deductible	70% after deductible
Outpatient Physician's Services	100% no deductible	70% after deductible
Physician's Office	100% after PCP or Specialist per office visit copay; 100% after PCP or Specialist per office visit copay if only x-ray and/or lab services are performed and billed	70% after deductible
Abortion *Includes elective and non-elective procedures*		
Inpatient Facility	$742 (subject to change annually) then 100% Precertification required	$742 (subject to change annually) then 70% Precertification required
Outpatient Surgical Facility	100% no deductible	100% no deductible
Physician's Office	100% no deductible	70% after deductible
Outpatient Professional Services	100% no deductible	100% no deductible
Inpatient Professional Services	100% no deductible	70% after deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment *Coverage will be provided for the following services:* • *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).* *Not covered: Artificial Insemination, In-vitro, GIFT, ZIFT, etc.*		
Office Visit (Lab and Radiology Test, Counseling)	100% after PCP or Specialist per office visit copay; 100% after PCP or Specialist per office visit copay if only x-ray and/or lab services performed **Note:** Charges billed by an independent x-ray/lab facility or outpatient hospital will be covered under the plan's x-ray/lab benefit.	70% after deductible
Inpatient Facility	$742 (subject to change annually) then 100% Precertification required	$742 (subject to change annually) then 70% Precertification required
Outpatient Facility	100% no deductible	100% no deductible
Physician Services	100% no deductible	70% after deductible
Organ Transplant *Includes all medically appropriate, non-experimental transplants*		
Inpatient Facility	100% at LifeSource center otherwise $742 (subject to change annually) then 100% Precertification required	$742 (subject to change annually) then 70% Precertification required
Physician's Services	100% at LifeSource center; otherwise 100%	70% after deductible
Travel Services Maximum - only available for LifeSource facilities	$10,000	Not covered
Durable Medical Equipment *Unlimited maximum per calendar year*	90% after deductible	70% after deductible
External Prosthetic Appliances including Orthotics with a diagnosis of diabetes *Unlimited maximum per calendar year*	90% after deductible	70% after deductible
Bariatric Surgery for severe Morbid Obesity *(must meet Medical necessity and severe morbid obesity standards)*		
Inpatient Facility	$742 (subject to change annually) then 100% Pre certification required	$742 (subject to change annually) then 70% Pre certification required
Outpatient Surgical Facility	100% no deductible	100% no deductible
Physician's Office	No charge after the PCP or Specialist per office visit copay	70% after deductible
Outpatient Professional Services	100% no deductible	100% no deductible
Biofeedback *(must meet Medical necessity)*	90% after deductible	70% after deductible
Wigs after loss of hair due to Chemotherapy *One wig per lifetime*	90% after deductible	90% after deductible
Nutritional Formula's	90% after deductible	70% after deductible
Nutritional Counseling *Up to 3 visits per condition per lifetime*	100% after PCP or Specialist per office visit copay	70% after deductible
Dental Care *Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.*		
Doctor's Office	100% after PCP or Specialist per office visit copay; 100% after PCP or Specialist per office visit copay if only x-ray and/or lab services are performed and billed	70% after deductible
Inpatient Facility	$742 (subject to change annually) then 100% Precertification required	$742 (subject to change annually) then 70% Precertification required
Outpatient Surgical Facility	100% no deductible	100% no deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Non Surgical TMJ *Up to a $500 maximum per calendar year* *Doctor's Office* ***Surgical TMJ** – Covered as any other illness*	100% after PCP or Specialist per office visit copay; 100% after PCP or Specialist per office visit copay if only x-ray and/or lab services are performed and billed	70% after deductible
Routine Foot Disorders – *Up to $250 calendar year maximum*	50% after PCP or Specialist per office visit copay; 100% after PCP or Specialist per office visit copay if only x-ray and/or lab services are performed and billed	50% after deductible
Mental Health/Substance Abuse	***Please note the following regarding Mental Health (MH) and Substance Abuse (SA) benefit administration:*** • Substance Abuse includes Alcohol and Drug Abuse services. • Transition of Care benefits are provided for a 90-day time period.	
Mental Health *Inpatient* *Includes Acute, Detox, Partial and Residential* *Outpatient Office Visits, includes Group Therapy* *All Other Outpatient Services*	$742 (subject to change annually) then 100% Pre certification required 100% after $40 per visit copay 90% after deductible	$742 (subject to change annually) then 70% Pre certification required 70% after deductible 70% after deductible
Substance Abuse (Alcohol & Drug) *Inpatient* *Includes Acute, Detox, Partial and Residential* *Outpatient*	$742 (subject to change annually) then 100% Pre certification required 100% not subject to copay or deductible	$742 (subject to change annually) then 70% Pre certification required 70% after plan deductible
MH/SA Service Specific Administration	Partial Hospitalization, Residential Treatment and Intensive Outpatient Programs: The following administration will apply: • *Partial Hospitalization and Residential Treatment: Covered as inpatient Mental Health and/or Substance Abuse* • *Intensive Outpatient Program (IOP):* Covered as outpatient Mental Health and / or Substance Abuse	
MH/SA Utilization Review & Case Management	Inpatient and Outpatient Management (CAP): • CBH provides utilization review and case management for In-network and Out-of-network Inpatient Services and In-network Outpatient Management services. • Includes Lifestyle Management Program (Stress & Tobacco)	

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Pre-existing Condition Limitation (PCL)	None	
Pre-Admission Certification – Continued Stay Review *Complete Care Management* **CIGNA's PAC/CSR is not necessary for Medicare Primary individuals*		
Pre-Admission Certification – Continued Stay Review (required for all inpatient admissions and required for selected outpatient procedures and diagnostic testing)	**Coordinated by Provider / PCP**	**Mandatory**: Employee is responsible for contacting CIGNA Healthcare. Penalties for non-compliance:
Complete Care Management Inpatient *- required for all inpatient admissions*		• $100 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.
Complete Care Management Outpatient Prior Authorization *- required for selected outpatient procedures and diagnostic testing* *In-Network: Coordinated by your physician*		• $100 penalty applied to outpatient procedures/diagnostic testing charges for failure to contact Cigna Healthcare and to precertify admission • Benefits are denied for any outpatient procedures/diagnostic testing reviewed by Cigna Healthcare and not certified
One Guide	Available by phone or throughout myCigna mobile application. One Guide helps you navigate the health care system and make the most of your health benefits and programs.	
Case Management	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.	

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: 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. 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. Reversal of male and female voluntary sterilization procedures.
14. 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.
15. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
16. Non-medical counseling or ancillary services, including, but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, 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.
17. 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.
18. 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."
19. Private hospital rooms and/or private duty nursing except as provided in the Home Health Services section of “Section IV. Covered Services and Supplies”.
20. 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.
21. Artificial aids, including but not limited to corrective orthopedic shoes except with diagnosis of diabetes, elastic stockings, garter belts, corsets and dentures.
22. 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.
23. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
24. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
25. 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.”
26. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
27. 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.
28. Dental implants for any condition.
29. 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.
30. Blood administration for the purpose of general improvement in physical condition.
31. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
32. Cosmetics, dietary supplements and health and beauty aids.
33. 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.
34. 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.
35. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
36. Telephone, e-mail & Internet consultations and telemedicine.
37. 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.