

SUMMARY OF BENEFITS

Your CIGNA Choice FundSM Health Savings Account-PPO 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.
- 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 programs and services designed to enhance your health and wellness. 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.
- **CIGNA Behavioral Advantage** emphasizes the mind-body connection. The program provides support from medical and mental health case managers, as well as a number of tools and resources, to help you take control of your health and wellness.

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 website 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**

- **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[®] 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 at the lowest out-of-pocket costs available under your plan. 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 “participating 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 Employees of Maricopa County HSA
Plan*

HSA-PPO - ASO

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 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 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.

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 2011, 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 remain in a qualified HSA plan and remain eligible to make/receive contributions. 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 calendar year. For enrollment less than 12 months during a calendar year, you may not be eligible for the maximum contribution for the calendar 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 or checkbook that come with your HSA.
- ❖ 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.

BENEFIT HIGHLIGHTS

IN-NETWORK

OUT-OF-NETWORK

Contract Year Combined Medical and CIGNA Pharmacy Deductible – Collective

Family 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.

	<i>Maximums Cross Accumulate</i>	<i>Maximums Cross Accumulate</i>
Individual (employee only; no covered dependents)	\$1,200	\$1,200
Family Maximum (employee+family)	\$2,400	\$2,400

Contract Year Combined Medical and CIGNA Pharmacy Out-of-Pocket Maximum – Collective

Family 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.

	<i>Maximums Cross Accumulate</i> Includes Plan Deductible	<i>Maximums Cross Accumulate</i> Includes Plan Deductible
Individual (employee only; no covered dependents)	\$2,000	\$2,000
Family Maximum (employee+family)	\$4,000	\$4,000

Coinsurance	CIGNA HealthCare pays 90% of eligible charges. You pay 10% of charges after plan deductible.	CIGNA HealthCare pays 70% of eligible charges. You pay 30% of charges after plan deductible.
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Precertification -Inpatient – 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
Precertification – Outpatient – PHS+ (required for selected outpatient procedures and diagnostic testing or outpatient services)	Coordinated by your physician	Participant must obtain approval for selected outpatient procedures and diagnostic testing; subject to penalty/reduction or denial for non-compliance

Lifetime Maximum (combined Medical and CIGNA Pharmacy)	Unlimited	Unlimited
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Pre-existing Condition Limitation	Yes Not applicable to anyone under 19 years old. Applies to any injury or sickness that you are diagnosed with and receive treatment for, or incur expenses for during the 90 days before you are insured by these benefits or you begin an eligibility waiting period (whichever is earlier). Please refer to your plan documents for specific details.	Yes
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Physician Services		
Primary Care Physician (PCP) Office Visit	10% of charges*; 10% of charges* if only x-ray and/or lab services are performed and billed.	30% of charges**
Specialty Physician Office Visit	10% of charges*; 10% of charges* if only x-ray and/or lab services are performed and billed.	30% of charges**
Consultant and Referral Physician Services		
Allergy Treatment/Injections - PCP or Specialty Physician	10% of charges*	30% of charges**
Allergy Serum (dispensed by physician in office)	10% of charges*	30% of charges**
Second Opinion Consultations (provided on voluntary basis)	10% of charges*	30% of charges**
Surgery Performed in the Physician's Office- PCP or Specialty Physician	10% of charges*	30% of charges**

Preventive Care		
Routine Preventive Care – Well Baby Care, Well Child Care and Adult Preventive Care	No charge, no plan deductible, including only x-ray and/or lab services are performed and billed.	Covered in-network only
Unlimited maximum per contract year		
Immunizations	No charge, no plan deductible	Covered in-network only

Preventive Mammograms, PSA, Pap Test	No charge, no plan deductible	Covered in-network only
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Diagnostic Mammograms, PSA, Pap Test	10% of charges*	30% of charges**
<i>(Note: Diagnostic Related Services are paid at the same level of benefits as other x-ray and lab services, based on place of services.)</i>		

Inpatient Hospital Services including:	10% of charges*	30% of charges*
<i>Semi-Private Room and Board</i>		Precertification required
<i>Diagnostic/Therapeutic Lab and X-ray</i>		
<i>Drugs and Medication</i>		
<i>Operating and Recovery Room</i>		
<i>Radiation Therapy and Chemotherapy</i>		
<i>Anesthesia and Inhalation Therapy</i>		
<i>MRIs, MRAs, CAT Scans, PET Scans, etc.</i>		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital Doctor's Visits/Consultations <i>Inpatient Hospital Professional Services</i>	10% of charges* 10% of charges*	30% of charges** 30% of charges**
Outpatient Facility Services <i>Operating Room, Recovery Room, Procedure Room and Treatment Room including:</i> <i>Diagnostic/Therapeutic Lab and X-rays</i> <i>Anesthesia and Inhalation Therapy</i> <i>Physician and Outpatient Professional Services</i>	10% of charges* 10% of charges*	30% of charges** 30% of charges**
Laboratory and Radiology Services (includes preadmission testing) <i>Physician's Office</i> <i>Outpatient Hospital Facility</i> <i>Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit)</i> <i>Independent X-Ray and/or Lab Facility</i> <i>Independent X-Ray and/or Lab Facility (in conjunction with an Emergency Room visit)</i>	10% of charges* 10% of charges* 10% of charges* 10% of charges* 10% of charges*	30% of charges** 30% of charges** 10% of charges* 30% of charges** 10% of charges*
Advanced Radiological Imaging <i>(MRIs, MRAs, CAT Scans, PET Scans, etc.)</i> <i>Outpatient Facility</i> <i>Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit)</i> <i>Physician's Office</i>	10% of charges* 10% of charges* 10% of charges*	30% of charges** 10% of charges* 30% of charges**
Short-Term Rehabilitative Therapy and Chiropractic Services – (includes physical, speech, occupational, chiropractic, pulmonary rehab & cognitive therapy) 120 days 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 Up to 36 days maximum per contract year#	10% of charges*; 10% of charges* if only x-ray and/or lab services are performed and billed. 10% of charges*	30% of charges** 30% of charges**
Emergency and Urgent Care Services <i>Physician's Office – PCP or Specialty Physician</i> <i>Hospital Emergency Room</i> <i>Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician)</i> <i>Urgent Care Facility or Outpatient Facility</i> <i>Ambulance</i>	10% of charges*; 10% of charges* if only x-ray and/or lab services are performed and billed. 10% of charges* 10% of charges* 10% of charges* 10% of charges*	
Maternity Care Services <i>Initial Office Visit to Confirm Pregnancy</i> <i>All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee)</i> <i>Office Visits not included in the total maternity fee performed by OB or Specialty Physician</i> <i>Delivery - Facility (Inpatient Hospital/Birthing Center Charges)</i>	10% of charges*; 10% of charges* if only x-ray and/or lab services are performed and billed. 10% of charges* 10% of charges*; 10% of charges* if only x-ray and/or lab services are performed and billed. 10% of charges*	30% of charges** 30% of charges** 30% of charges** 30% of charges* Precertification required
Inpatient Services at Other Health Care Facilities Skilled Nursing, Rehabilitation and Sub-Acute Facilities 90 days maximum per contract year# combined for all facilities listed	10% of charges*	30% of charges**
Home Health Services - Includes outpatient private duty nursing when approved as medically necessary, Unlimited days maximum per contract year; 16 hour maximum per day#	10% of charges*	30% of charges**

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Family Planning Services Office Visits (lab & radiology tests, counseling)</p> <p>Vasectomy/Tubal Ligation (excludes reversals) Inpatient Facility</p> <p>Outpatient Facility Services Physician's Services – Inpatient or Outpatient Physician's Office</p>	<p>10% of charges*; 10% of charges* if only x-ray and/or lab services are performed and billed.</p> <p>10% of charges*</p> <p>10% of charges*</p> <p>10% of charges*</p> <p>10% of charges*; 10% of charges* if only x-ray and/or lab services are performed and billed.</p>	<p>30% of charges**</p> <p>30% of charges* Precertification required 30% of charges** 30% of charges** 30% of charges**</p>
<p>Infertility Services Office Visit (lab & radiology tests, counseling) – PCP or Specialty Physician</p> <p>Treatment/Surgery (includes artificial insemination) (excludes in-vitro fertilization, GIFT, ZIFT, etc.) Inpatient Facility Outpatient Facility Services Physician's Services – Inpatient or Outpatient</p>	<p>10% of charges*; 10% of charges* if only x-ray and/or lab services are performed and billed.</p> <p>10% of charges*</p> <p>10% of charges*</p> <p>10% of charges*</p>	<p>Covered in-network only</p> <p>Covered in-network only Covered in-network only Covered in-network only</p>
<p>TMJ – Surgical and Non-surgical</p>	<p>Not Covered</p>	<p>Not Covered</p>
<p>Mental Health Inpatient – Unlimited maximum per contract year</p> <p>Outpatient Mental Health (includes Individual, Group Therapy and Intensive Outpatient) – Unlimited maximum per contract year</p> <p>Physician's Office</p> <p>Outpatient Facility</p>	<p>10% of charges*</p> <p>10% of charges*</p> <p>10% of charges*</p> <p>10% of charges*</p>	<p>30% of charges* Precertification required</p> <p>30% of charges**</p> <p>30% of charges**</p>
<p>Substance Abuse Inpatient – Unlimited maximum per contract year</p> <p>Outpatient Substance Abuse (includes Individual and Intensive Outpatient) – Unlimited maximum per contract year</p> <p>Physician's Office</p> <p>Outpatient Facility</p>	<p>10% of charges*</p> <p>10% of charges*</p> <p>10% of charges*</p> <p>10% of charges*</p>	<p>30% of charges* Precertification required</p> <p>30% of charges**</p> <p>30% of charges**</p>
<p>Durable Medical Equipment Unlimited maximum per contract year</p>	<p>10% of charges*</p>	<p>30% of charges**</p>
<p>External Prosthetic Appliances Unlimited maximum per contract year</p>	<p>10% of charges*</p>	<p>30% of charges**</p>
<p>Hearing Services Hearing Aids \$2,000 maximum per ear per member every three years. All providers covered.</p>	<p>10% of charges*</p> <p>10% of charges*</p>	<p>30% of charges**</p> <p>30% of charges**</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Prescription Drugs CIGNA Pharmacy Retail Drug Program <i>Generic*** drugs on the Prescription Drug List for a 30-day supply</i> <i>Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent for a 30-day supply</i> <i>Brand Name*** drugs designated as non-preferred on the Prescription Drug List for a 30-day supply</i></p> <p>CIGNA Home Delivery Program <i>Generic*** drugs on the Prescription Drug List for a 90-day supply</i> <i>Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent for a 90-day supply</i> <i>Brand Name*** drugs designated as non-preferred on the Prescription Drug List for a 90-day supply</i> ***Designated as per generally-accepted industry sources and adopted by CG</p> <p>Note: Prescription medications used to prevent any of the following medical conditions are not subject to the plan deductible: Hypertension, high cholesterol, diabetes, asthma, osteoporosis, stroke, prenatal nutrient deficiency.</p> <p>If you are receiving a Generic or Preferred Brand name medication that is on the CIGNA Formulary noted as a Preventive Medication (PM), you will receive this medication at no cost.</p>	<p>30% of charges per prescription/refill, after plan deductible</p> <p>40% of charges per prescription/refill, after plan deductible</p> <p>50% of charges per prescription/refill, after plan deductible</p> <p>30% of charges per prescription/refill, after plan deductible</p> <p>40% of charges per prescription/refill, after plan deductible</p> <p>50% of charges per prescription/refill, after plan deductible</p>	<p>Covered in-network only</p> <p>Covered in-network only</p> <p>Covered in-network only</p> <p>Covered in-network only</p> <p>Covered in-network only</p> <p>Covered in-network only</p>

Footnotes

- * Services are subject to contract year deductible.
- ** Out-of-network services are subject to the 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.

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 benefits.

Regarding In-Network Services:

- All services must be provided by one of the participating 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 participating provider.
- All out-of-network hospital admissions and certain outpatient surgical and diagnostic procedures 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 (not all-inclusive):

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. Treatment of TMJ disorder.
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.

Benefit Exclusions (continued)

7. 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.
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 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.
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 than ostomy supplies 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 corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
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 for the purpose of travel, or 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.
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. Expenses incurred for medical treatment by a person age 65 or older, who is covered under the plan as a retiree, or his dependent, when payment is denied by the Medicare plan because treatment was not received from a participating provider of the Medicare plan.
27. 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.
28. The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Cosmetic Surgery and Therapies; Rhinoplasty; Abdominoplasty/Panniculectomy; Blepharoplasty; Redundant Skin Surgery; Removal of Skin Tags; 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; 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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