

# Guide to Your CIGNA Choice Fund – HRA

## Explanation of Benefits

When you, your doctor or other provider files a claim under your CIGNA HealthCare benefits plan, you will receive an Explanation of Benefits (EOB). The EOB is the financial story of each care encounter. Provider information, dates, charges, and amounts covered, as well as a running summary of deductibles are provided to help you understand how your plan works for you.

Connecticut General Life Insurance Company  
 CHATTANOOGA CLAIM OFFICE  
 P.O. BOX 188002  
 CHATTANOOGA, TN 37422-8002



Connecticut General Life Insurance Company

“ABC” Employee Benefit Plan

Subscriber’s Name  
 Subscriber’s Address  
 City, State 99999-9999

ALL THE INFORMATION OUR CUSTOMER SERVICE REPRESENTATIVES WILL NEED WHEN HANDLING YOUR QUESTIONS

Subscriber ID:  
 455120672

|  |                |
|--|----------------|
| Operation Location/Group No:<br>3089-9-4120222 | Pay Loc:<br>43 |
|--|----------------|

Date through which claims for these benefits were processed:

January 5, 2005

How to Contact Us



Mail to the return address in the upper left corner of this page



<http://www.cigna.com>



Phone: 1.800.244.6224

QUESTION? KEY CONTACT INFORMATION

UP-FRONT, TOP-LINE SUMMARY OF THE BENEFIT OR PAYMENT

THIS IS NOT A BILL. Please retain this Benefits Statement for your records. Please provide the subscriber ID for all inquiries and claim submissions.

IF YOU HAVE DOLLARS IN YOUR HEALTH FUND, THEY WILL BE USED TO PAY YOUR PROVIDER

### Explanation of Medical Benefits, Health Reimbursement Account (HRA)

You have received this Explanation of Medical Benefits because a claim for Medical Benefits was received by this office.

Please review and retain this Explanation of Medical Benefits for your records.

|   |           |                               |        |
|---|-----------|-------------------------------|--------|
| This statement identifies benefits for: | Joe CIGNA |                               |        |
| Total of the charges received:          | 315.00    | Total HRA Payment             | 233.00 |
| Medical Plan Payments:                  | 0.00      | Total Patient Responsibility: | 0.00   |

### Rights of Review and Appeal – For Employee

- Call member services at the toll free number on this Explanation of Benefits (EOB) or your ID card if you have questions regarding this EOB.
- If you’re not satisfied with this coverage decision, you can start the EOB (unless a longer time is permitted by your plan).
- Send a copy of this EOB along with any relevant additional information (e.g. benefit documents, clinical records) which helps to demonstrate that your claim is covered under the plan. Contact Member Services if you need further instructions on how.
- Be sure to include your 1) Name, 2) Operation Location/Group Number, 3) Employee/Patient ID number, 4) Name of the patient and relationship, and 5) “Attention: Appeals Unit” on all supporting documents.
- You are entitled to receive free upon request access to, and copies of, all documents, records and other information relevant to your claim for benefits.
- You will be notified of the final decision in a timely manner, as described in your plan materials.. If your plan is governed by ERISA, you also have the right to bring legal action under section 502(a) or ERISA following our decision.

Please note: This provides a view of the variable information and is only a SAMPLE EOB. Your own form or information may vary depending on your plan details. Use this as a guideline and refer to the EOB you receive for complete details.

**SERVICE DETAIL  
IN A HORIZONTAL,  
STATEMENT-TYPE  
FORMAT – CLEAR AND  
CONCISE!**

| Subscriber Name             |                   |                            |                |                              | Subscriber ID            |                               |                                    |                  |                   | Patient Name              |                 | This is not a bill                        | Page 1            |
|-----------------------------|-------------------|----------------------------|----------------|------------------------------|--------------------------|-------------------------------|------------------------------------|------------------|-------------------|---------------------------|-----------------|---|-------------------|
| Medical Plan Claim Activity |                   |                            |                |                              |                          |                               |                                    |                  |                   | Patient Responsibility    |                 |   |                   |
| Service Date and Type       | Submitted Charges | <b>A</b> Provider Discount | <b>B</b> Other | <b>C</b> Not Covered Charges | <b>D</b> Covered Charges | <b>E</b> Patient Deduct/Copay | <b>F</b> Covered Balance Remaining | <b>G</b> Paid At | Medical Plan Pays | <b>H</b> Submitted to HRA | Paid out of HRA | <b>I</b> Remaining Patient Responsibility | <b>J</b> See Note |
| 01/01/2006 SURGERY          | 250.00            | 75.00                      |                |                              | 175.00                   | 175.00                        | 0.00                               |                  | 0.00              | 175.00                    | 175.00          | 0.00                                      | A, B              |
| 01/01/2006 ANESTHESIST      | 65.00             | 7.00                       |                |                              | 58.00                    | 58.00                         | 0.00                               |                  | 0.00              | 58.00                     | 58.00           | 0.00                                      | A, B              |

\$500.00 OUT OF NETWORK DEDUCTIBLE HAS BEEN SATISFIED FOR 2006  
 \$500.00 IN NETWORK DEDUCTIBLE HAS BEEN SATISFIED FOR 2006  
 \$500.00 HAS BEEN APPLIED TOWARD THE \$2,000 OUT OF NETWORK 'OUT-OF-POCKET LIMIT' FOR 2006  
 \$500.00 HAS BEEN APPLIED TOWARD THE \$1,000 IN NETWORK 'OUT-OF-POCKET LIMIT' FOR 2006

|                                  |           |
|----------------------------------|-----------|
| Plan Payment                     | \$ 0.00   |
| Total Patient Responsibility     | \$ 233.00 |
| Less Choice Fund HRA Payment     | \$ 233.00 |
| Remaining Patient Responsibility | \$ 0.00   |

**ADDITIONAL  
EXPLANATION  
PROVIDED IN NOTES  
REFERENCED HERE  
AND PRINTED  
BELOW**

**Notes**

- A** THANK YOU FOR USING A CIGNA HEALTHCARE PREFERRED PROVIDER. THIS REPRESENTS YOUR SAVINGS, SO YOU ARE NOT REQUIRED TO PAY THIS AMOUNT. THIS PROVIDER IS PROHIBITED FROM BILLING THE PATIENT THE DIFFERENCE. IF YOU HAVE ALREADY PAID THE FULL AMOUNT, PLEASE REQUEST REIMBURSEMENT FROM YOUR PROVIDER.
- B** FULLY PAID FROM HRA ACCOUNT.

| Product             | Period Covered          | <b>K</b> Beginning Fund Balance | Prior Year <b>L</b> Carryover Balance | Payments from this Statement | Year to Date Payments | Available Balance |
|---------------------|-------------------------|---------------------------------|---------------------------------------|------------------------------|-----------------------|-------------------|
| General Medical HRA | 01/01/2006 - 12/31/2006 | 1,000.00                        |                                       | 233.00                       | 500.00                | 500.00            |

**Why wait for the mail? View claim details, eligibility or benefits online anytime at [www.mycigna.com](http://www.mycigna.com).**

**Definitions of terms used on the detail section of this statement.**

- A** Provider Discount: Part of "Submitted Charges" reduced for discount arrangements with the Provider.
- B** Other: Part of "Submitted Charges" not covered by the plan and not the patient's responsibility.
- C** Not Covered Charges: Part of "Submitted Charges" not covered by the plan but remain the patient's responsibility.
- D** Covered Charges: Part of the "Charge(s) Submitted" eligible for coverage under the benefit plan.
- E** Patient Deduct/Copay: Portion of the bill applied toward the patient's deductible or copay (if any).
- F** Covered Balance Remaining: Covered Charges minus "Patient Deduct/Copay" (if any).
- G** Paid At: The percentage of the "Covered Balance" which will be paid according to the benefit plan.
- H** Submitted to HRA: Amount remaining after the medical plan pays, forwarded to the HRA for payment.
- I** Patient Remaining Responsibility: Amount of patient responsibility remaining after the medical plan and HRA pays.
- J** See Note: Explanation of the CIGNA HealthCare payment calculation. Please see the final page of the Explanation of Medical Benefits for the written description of the Note.
- K** Beginning Fund Balance: Amount funded at the beginning of the plan period for current year claims.
- L** Prior Year Carryover Balance: If applicable, these are funds available from prior year unused HRA funds and/or incentive arrangements.

**YEAR TO DATE  
PAYMENTS INCLUDE  
PAYMENTS FROM THIS  
STATEMENT**

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"CIGNA" and "CIGNA HealthCare" refer to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these operating subsidiaries and not by CIGNA Corporation. These operating subsidiaries include Connecticut General Life Insurance Company, 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. In Arizona, HMO plans are offered by CIGNA HealthCare of Arizona, Inc. In California, HMO plans are offered by CIGNA HealthCare of California, Inc. In Connecticut, HMO plans are offered by CIGNA HealthCare of Connecticut, Inc. In Virginia, HMO plans are offered by CIGNA HealthCare Mid-Atlantic, Inc. In North Carolina, HMO plans are offered by CIGNA HealthCare of North Carolina, Inc. All other medical plans in these states are insured or administered by Connecticut General Life Insurance Company.