Guide to Your Explanation of Benefits

CIGNA HealthCare
A Business of Caring.

When you or your doctor or other provider file a claim under your CIGNA HealthCare benefits plan, you will receive an Explanation of Benefits (EOB) form. 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
CONN GEN LIFE INS CO
P.O. BOX 12345
ANYTOWN, USA 12345

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 A MEMBER INQUIRY

QUESTION? KEY CONTACT INFORMATION

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

CIGNA HealthCare

Subscriber ID:
123456789

Operation Location/Group No:	**Pay Loc:**
12345-6-7891234	**218**

Date through which claims for these benefits were processed:
07/09/04

How to Contact Us

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

http://www.cigna.com

Phone: 1.800.XXX.XXXX

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

Explanation of Medical Benefits

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:	**John Smith**		
Total of the charges received:	**125.00**		
Plan Liability:	**65.00**	**Total Patient Responsibility:**	**20.00**

Rights of Review and Appeal – For Employee

*(**Please Note:** This section states appeal rights that you may have and the process you will need to use to file an appeal. For details, you should look to the Explanation of Benefits form and your Summary Plan Description.)*

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.

Subscriber Name:	Subscriber ID:	Member or Patient Name:	This Is Not a Bill	Page:
John Smith	123456789	John Smith	Retain for Your Records	01

A Service Date(s)	B Type of Service	C Charge(s) Submitted	D Not Covered/ Discount	E Amount Covered	F Patient Deduct/Copay	G Covered Balance	H Percent	I Plan Liability	J See Note
PROVIDER NAME: DR. JANE DOE				REFERENCE NUMBER: 865 0419093731				PROCESS DATE: 07/09/2004	
06/17/2004	Physician Office Visit	125.00	40.00	85.00	20.00	65.00	100%	65.00	A
		0.00	0.00	0.00	0.00	0.00	0	0.00	
TOTAL		125.00	40.00	85.00	20.00	65.00		65.00	

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

ADDITIONAL EXPLANATION PROVIDED IN NOTES REFERENCED HERE AND PRINTED BELOW

$300.00 HAS BEEN APPLIED TOWARDS THE $300 IN NETWORK DEDUCTIBLE FOR 2004
$31.47 HAS BEEN APPLIED TOWARDS THE $4,500 OUT OF NETWORK 'OUT-OF-POCKET LIMIT' FOR 2004
$425.00 HAS BEEN APPLIED TOWARDS THE $2,000 IN NETWORK 'OUT-OF-POCKET LIMIT' FOR 2004

**NOTES ON BENEFIT DETERMINATION:

L	COMPREHENSIVE BENEFITS	$65.00
	PLAN PAYMENT	$65.00
	BALANCE	$20.00

PAYMENT OF $65.00 WILL BE PAID ON 07/12/2004 TO JANE DOE, MD
NOTE: YOUR PLAN'S BENEFITS HAVE BEEN REDUCED BY OTHER COVERAGE WHERE APPLICABLE. K

Why wait for the mail? View claim details, eligibility or benefits online anytime at www.mycigna.com.

A. THANK YOU FOR USING A CIGNA HEALTHCARE PREFERRED PROVIDER. THIS REPRESENTS YOUR SAVINGS, SO YOU ARE NOT J REQUIRED TO PAY THIS AMOUNT.

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

A	**Service Date(s):**	The date the patient received the services recorded on this statement.
B	**Type of Service:**	Description of the type of service rendered.
C	**Charge(s) Submitted:**	Amount billed for the services.
D	**Not Covered/Discount:**	Part of the "Charge(s) Submitted" not covered under the benefit plan (eg., discount amount).
E	**Amount Covered:**	Part of the "Charge(s) Submitted" eligible for coverage under the benefit plan.
F	**Patient Deduct/Copay:**	Portion of the bill applied toward the patient's deductible or copay (if any).
G	**Covered Balance:**	"Amount Covered" minus "Patient Deduct/Copay" (if any).
H	**Percent:**	The percentage of the "Covered Balance" which will be paid according to the benefit plan.
I	**Plan Liability:**	What the plan would pay before coordination of benefits with another insurance carrier.
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	**Other Coverage:**	The amount of another insurance carrier's payment.
L	**Balance (if any):**	Patient responsibility amount for this claim.

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