

CONNECTICUT GENERAL LIFE INSURANCE COMPANY
 CHATTANOOGA CLAIM OFFICE
 P.O. BOX 182223
 CHATTANOOGA TN 37422-8002



CIGNA HealthCare

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

CHOICE FUND 2.0 - FIN CARD ACCOUNT

Subscriber ID:

U92839255

Operation Location / Group No.	Payloc
31532-9-5100012	043

Date through which claims for these benefits were processed: **JANUARY 10, 2008**

How to Contact Us

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

<http://www.cigna.com>

Phone: (800) 244-6224

TANK JOHNSON
 202 FOOT STREET
 BLOOMFIELD CT 06002

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, 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: TANK JOHNSON

Total of the charges received:	800.00	HRA Payment:	
Medical Plan Payments:	522.00	Remaining 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 Appeal process by submitting a written request to the address listed in your plan materials within 180 days of receipt of this 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 and where to send your request for review.
- 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) of ERISA following our review.

Definitions of terms used on the detail section of this statement

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

Explanation of Medical Benefits and Choice Fund Health Reimbursement Account



Subscriber Name TANK JOHNSON	Subscriber ID U92839255	Patient Name TANK JOHNSON	THIS IS NOT A BILL Retain for Your Records	Page 1
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Medical Plan Claim Activity	Patient Responsibility
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Service Date and Type	Submitted Charges	Provider Discount	Other	Not Covered Charges	Covered Charges	Patient Deduct/Copay	Covered Balance Remaining	Paid at	Medical Plan Pays	Submitted to HRA	Paid out of HRA	Remaining Patient Responsibility	See Note
	a	b	c	d	e=a-b-c-d	f	g=e-f	h	i	j=d+f+g-i	k	l=j-k	

PROVIDER NAME: RAY O BAHADO-SINGH MD REFERENCE NUMBER: 043 0801030017 RECEIVE DATE: 01/10/2008 PROCESS DATE: 01/10/2008
01/09/2008 -

PHYSICIAN	350.00	0.00	200.00	0.00	150.00	0.00	150.00	80	120.00	0.00	0.00	0.00	A
TOTAL	350.00	0.00	200.00	0.00	150.00	0.00	150.00		120.00	0.00	0.00	0.00	

** NOTES ON BENEFIT DETERMINATION:
 PLAN PAYMENT \$120.00
 OTHER COVERAGE \$150.00
 TOTAL PATIENT RESPONSIBILITY \$0.00

PROVIDER NAME: RAY O BAHADO-SINGH MD REFERENCE NUMBER: 043 0801030018 RECEIVE DATE: 01/10/2008 PROCESS DATE: 01/10/2008
01/10/2008 -

PHYSICIAN	200.00	0.00	10.00	0.00	190.00	0.00	190.00	80	152.00	0.00	0.00	0.00	A
TOTAL	200.00	0.00	10.00	0.00	190.00	0.00	190.00		152.00	0.00	0.00	0.00	

** NOTES ON BENEFIT DETERMINATION:
 PLAN PAYMENT \$152.00
 TOTAL PATIENT RESPONSIBILITY \$0.00

PAYMENT OF \$272.00 WILL BE PAID ON 01/10/2008 TO RAY O BAHADO-SINGH MD

PROVIDER NAME: SOCORRO GENERAL HSP REFERENCE NUMBER: 043 0801030020 RECEIVE DATE: 01/10/2008 PROCESS DATE: 01/10/2008
12/29/2007 -

OPERATING ROOM	250.00	0.00	0.00	0.00	250.00	0.00	250.00	100	250.00	0.00	0.00	0.00	
TOTAL	250.00	0.00	0.00	0.00	250.00	0.00	250.00		250.00	0.00	0.00	0.00	

** NOTES ON BENEFIT DETERMINATION:
 PLAN PAYMENT \$250.00
 TOTAL PATIENT RESPONSIBILITY \$0.00

PAYMENT OF \$250.00 TO SOCORRO GENERAL HSP

YOU SHOULD NOT RECEIVE BILLING FOR ANY OTHER AMOUNTS OTHER THAN THOSE LISTED BESIDE "BALANCE".

IF YOU HAVE ANY QUESTIONS REGARDING THIS CLAIM, PLEASE INCLUDE THE REFERENCE NUMBER ON INQUIRIES.

PLEASE REFER TO YOUR ID CARD FOR THE ACCOUNT NUMBER. TCS-SOP

WHY WAIT FOR THE MAIL? VIEW CLAIM DETAILS, ELIGIBILITY OR BENEFITS ONLINE ANYTIME AT WWW.MYCIGNA.COM.

A) THIS PROVIDER ACCEPTS MEDICARE'S ASSIGNMENT AND AGREES TO CHARGE ONLY THE AMOUNT APPROVED BY MEDICARE. THIS AMOUNT WAS DISALLOWED BY MEDICARE.