SUMMARY OF BENEFITS

Your CIGNA HealthCare PPO plan

CIGNA HealthCare

Features that Add Value

- The CIGNA HealthCare 24-Hour Health Information Line℠ connects you **to registered nurses** and a **library** of hundreds of recorded programs on important health topics 24 hours a day, 7 days a week, from anywhere in the U.S.
- **CIGNA HealthCare *Healthy Rewards®*** includes special offers for **discounts** on health-related products and services. Just call 1.800.870.3470 or visit our web site at www.cigna.com.
- Prescription drug coverage is a **part of your plan**. More than 49,000 pharmacies participate nationwide, so you can have your prescription filled **wherever you go**. Mail-order service means quick, **convenient** delivery of your medications right to your home.

Quality Service Is Part of Quality Care

- **Responsive service** -- Customer Service representatives have the authority to **solve problems** on the phone, usually on the first call.
- **www.cigna.com** – Visit our **interactive Web site** to learn more about your plan and get health information, 24 hours a day.
- **We Speak Many Languages℠**. Our Language Line Services means that you can **talk with us** in 140 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 your children through age 2 and any additional preventive care benefits described in the Benefits Highlights.
- The CIGNA HealthCare Well-Aware Program for Better Health® can **help you manage** certain chronic conditions.
- The CIGNA HealthCare Healthy Babies® program provides you with education and support to help you have a **healthy pregnancy** and **a healthy baby.**

You Can Depend on CIGNA HealthCare

- **Quality comes first**. We select "preferred 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

- You get access to quality care at the lowest out-of-pocket costs available under your plan by seeing network providers. You also get 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 "preferred providers", but you're still covered for visits to other providers.

For Employees of Irving ISD

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Doctor Office Visit		
Routine Preventive Care for Children through age 2 (including immunizations)	No charge after $25 per office visit copay, 20% of charges* for x-ray/lab if billed by a separate facility	40% of charges**
Immunizations	No charge	40% of charges**
Routine Preventive Care for Children and Adults from age 3 (including immunizations)	No charge after $25 per office visit copay, 20% of charges* for x-ray/lab if billed by a separate facility	40% of charges**
Adult/Child Medical Care for Illness or Injury	No charge after $25 per office visit copay	40% of charges**
Surgery Performed in a Physician's Office	20% of charges*	40% of charges**
Routine Mammogram, PSA, Pap Test	100% of charges if billed by a separate outpatient diagnostic facility	40% of charges**
Specialty Physician Office Visit		
Office Visits-Consultant and Physician Services	No charge after $25 per office visit copay	40% of charges**
Surgery Performed in Physician's Office	20% of charges*	40% of charges**
Allergy Treatment/Injections	No charge after either the $25 per office visit copay or the actual charge, whichever is less	40% of charges**
Inpatient Hospital Services including*:* *Semi-Private Room and Board* *Physician Services* *Diagnostic/Therapeutic Lab and X-ray* *Drugs and Medication* *Operating and Recovery Room* *Radiation Therapy and Chemotherapy* *Anesthesia and Inhalation Therapy*	$500 copayment per admission, plus 20% of charges Precertification required	$750 copayment per admission, plus 40% of charges Precertification required
Outpatient Facility Services includes*:* *Operating Room, Recovery Room, Procedure Room and Treatment Room including:* *Physician Services* *Diagnostic/Therapeutic Lab and X-rays* *Anesthesia and Inhalation Therapy*	20% of charges*	40% of charges**
Outpatient Preadmission Testing		
Office Visit (PCP or Specialist)	No charge after $25 office visit copay; 20% of charges* for x-ray/lab if billed by separate facility	40% of charges**
Outpatient Facility	20% of charges*	40% of charges**
Laboratory and Radiology Services		
MRIs, MRAs, CAT Scans and PET Scans	20% of charges*	40% of charges**
Other Laboratory and Radiology Services	20% of charges*	40% of charges**
Short-Term Rehabilitative Therapy *Includes: Cardiac Rehab, Physical Therapy, Speech Therapy, Occupational Therapy, Chiropractic Therapy – (includes Chiropractors)*	No charge after $25 office visit copay	40% of charges**
Chiropractic Services ***$1,500 chiropractic maximum per calendar year##***	No charge after $25 office visit copay	40% of charges**
Prescription Drugs		
CIGNA Pharmacy Plus Retail Drug Program *Generic Push, Incentive Formulary Plan* *Includes oral contraceptives and contraceptive devices, diabetic drugs & supplies, self-administered injectables & prescription prenatal vitamins.*	$15 per 30-day supply for generic drugs $30 per 30-day supply for brand-name drugs $45 per 30 day supply for non-preferred brand-name drugs	40% of charges, no deductible 40% of charges, no deductible 40% of charges, no deductible
CIGNA Tel-Drug Mail Order Drug Program	$30 per 90-day supply for generic drugs $60 per 90-day supply for brand-name drugs $90 per 90-day supply for non-preferred brand-name drugs	Covered in-network only Covered in-network only Covered in-network only
Emergency and Urgent Care Services		*Care will be provided at in-network levels if it meets the "prudent layperson" definition of an emergency. Otherwise 40% of charges***
Physician's Office	No charge after $25 office visit copay	
Hospital Emergency Room	$50 copayment per visit (*waived if admitted*) plus 20% of charges	
Participating Urgent Care or Outpatient Facility	No charge after $25 per visit copay	
Ambulance	20% of charges*	
Maternity Care Services		
Initial Office Visit to Confirm Pregnancy	No charge after $25 office visit copay	40% of charges**
All subsequent prenatal visits, postnatal visits and Delivery	20% of charges*	40% of charges**
Hospital Charges	$500 per admission, plus 20% of charges*	$750 per admission, plus 40% of charges*
Physician Charges	20% of charges*	40% of charges**
Inpatient Services at Other Health Care Facilities *Skilled Nursing, Rehabilitation, Hospice and Sub-Acute Facilities* 60 days maximum per calendar year#	20% of charges*	40% of charges**

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Home Health Services	20% of charges*	40% of charges**
Family Planning Services		
Office Visits (tests, counseling)	No charge after $25 office visit copay; 20% of charges* for x-ray/lab if billed by separate facility	40% of charges**
Vasectomy/Tubal Ligation (excludes reversals)		
Inpatient Facility	$500 per admission, plus 20% of charges (precertification required)	$750 per admission, plus 40% of charges (precertification required)
Outpatient Facility	20% of charges*	40% of charges**
In Physician's Office	20% of charges*	40% of charges**
Infertility Services		
Office Visit (tests, counseling)	No charge after $25 office visit copay; 20% of charges* for x-ray/lab if billed by separate facility	Covered in-network only
Treatment/Surgery (excludes in-vitro fertilization, artificial insemination, GIFT, ZIFT, etc.)		
Inpatient Facility	$500 per admission, plus 20% of charges precertification required	Covered in-network only
Outpatient Surgical Facility	20% of charges*	Covered in-network only
In Physician's Office	20% of charges*	Covered in-network only
Mental Health Services and Substance Abuse Treatment		
Inpatient Mental Health Services	20% of charges* *30 days maximum per calendar year#*	40% of charges*, *30 days maximum per calendar year#*
*Inpatient Serious Mental Health Services^*	$500 copayment per admission, plus 20% of charges*; 45 *days maximum per calendar year#*	$750 per admission, plus 40% of charges*, *45 days maximum per calendar year#*
Outpatient Individual Mental Health Services	$25 copayment per office visit; *20 visits maximum per calendar year#*	40% of charges** *30 visits maximum per calendar year#*
*Outpatient Individual Serious Mental Health Services^*	20% of charges*; 60 *visits maximum per calendar year#*	40% of charges** *60 visits maximum per calendar year#*
Outpatient Mental Health Group Therapy *Two Group therapy sessions equal one Individual therapy session*	20% of charges*	*40% of charges***
Substance Abuse (Alcohol & Drug) ***Limited to 3 separate series per lifetime***		
Inpatient Substance Abuse Rehabilitation Services	$500 copayment per admission, plus 20% of charges	$750 per admission, plus 40% of charges
Outpatient Individual Substance Abuse Rehabilitation Services	$25 copayment per office visit	40% of charges**
Outpatient Group Substance Abuse Rehabilitation Services *Two Group therapy sessions equal one Individual therapy session*	$25 copayment per office visit	40% of charges**
Inpatient Substance Abuse Detoxification Services	$500 copayment per admission, plus 20% of charges	$750 per admission, plus 40% of charges
Outpatient Substance Abuse Detoxification Services	$25 copayment per office visit	40% of charges**
Durable Medical Equipment	20% of charges*	40% of charges**
External Prosthetic Appliances $10,000 maximum per calendar year#	20% of charges*	40% of charges**
OTHER BENEFIT INFORMATION		
Annual Deductible		
Individual	$300	$700
Family	$600	$1,400
Annual Out-of-Pocket Maximum		
Individual	$2,000 plus deductible	$4,000 plus deductible
Family	$4,000 plus deductible	$8,000 plus deductible
Coinsurance	CIGNA HealthCare pays 80% of eligible charges. You pay 20% of charges after plan deductible.	CIGNA HealthCare pays 60% of eligible charges. You pay 40% of charges after plan deductible.
Precertification (Inpatient)	Participant must obtain approval	Participant must obtain approval
Lifetime Maximum	$1,000,000#	$1,000,000#
Pre-existing Condition Limitation	Yes	Yes

Services are subject to calendar year deductible

***** Services are subject to calendar year deductible and reasonable and customary charge limitations.***

 # *In-network and out-of-network services apply to the same treatment or dollar maximum*.

^ "Serious Mental Illnesses" are Schizophrenia; paranoid and other psychotic disorders; bipolar disorder (hypomanic, manic, depressive and mixed); major depressive disorders; schizoaffective disorders (bipolar or depressive); pervasive developmental disorders; obsessive-compulsive disorder; and depression in childhood and adolescence. Visits for the sole purpose of managing and adjusting medications used to treat "Serious Mental Illness" will not be counted toward outpatient limits.

Footnotes:

Regarding In-Network and Out-of-Network Services:

- *Once the out-of-pocket maximum is reached, the plan pays 100% of eligible charges for the remainder of the plan year, except for prescription drug copays which continue to be paid at the levels specified.*
- *All inpatient hospital admissions require Preadmission Certification and Continued Stay Review. Failure to obtain Preadmission Certification and/or Continued Stay Review may result in non-compliance penalties and/or reduction of benefits. Call the toll free number on your CIGNA HealthCare ID Card.*
- *Coverage for pre-existing conditions will not be covered under this plan unless continuously insured for one year.*

Regarding In-Network Services: *All services must be provided by one of the preferred 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 preferred provider.*

CASE MANAGEMENT

Coordinated by Intracorp . 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.

These are examples of the exclusions in your plan. 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.

Your plan provides coverage for medically necessary services. Your plan does not provide coverage for the following except as required by law:

1. Services that are not medically necessary, except specifically outlined preventive care.
2. Charges which the person is not obligated to pay.
3. Charges made by a hospital owned by or performing services for the U.S. government if the charges are directly related to a sickness or injury connected to military service.
4. Custodial services not intended primarily to treat a specific injury or sickness, or any education or training.
5. Experimental, investigational or unproven procedures and treatments.
6. Cosmetic surgery, unless: (a) a person receives an injury which results in bodily damage requiring surgery; (b) it qualifies as reconstructive surgery performed on a person following surgery, and both the surgery and the reconstructive surgery are essential and medically necessary; (c) it qualifies as reconstructive surgery following a mastectomy, including surgery and reconstruction of the other breast to achieve symmetry.
7. Reports, evaluations, examinations, or hospitalizations not required for health reasons, such as employment, insurance or government licenses and court ordered forensic or custodial evaluations.
8. Treatment of the teeth or periodontium, unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an injury to sound natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; or (c) charges made by the outpatient department of a Hospital in connection with surgery.
9. Reversal of voluntary sterilization procedures.
10. Infertility drugs, in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collections, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
11. Transsexual surgery and related services.
12. Treatment for erectile dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile dysfunction.
13. Therapy to improve general physical condition.
14. Eyeglasses, hearing aids or examinations and prescription fitting, except as provided in the Certificate or Summary Plan Description.
15. Certain internal or external prostheses, or replacement of external prostheses due to wear and tear, loss, theft or destruction.
16. Surgical treatment for correction of refractive errors, including radial keratotomy.
17. Prescription and non-prescription drugs, except as provided in the Certificate or Summary Plan Description.
18. Routine foot care.
19. Any injury or sickness arising out of , or in the course of, any employment for wage or profit.
20. Charges for over the counter disposable or consumable supplies, except as provided under “Covered Expenses” in the Certificate or Summary Plan Description.
21. Charges in excess of reasonable and customary limitations.
22. Charges for medical and surgical services intended primarily for the treatment or control of obesity which are not medically necessary.
23. Speech therapy which is not restorative in nature.
24. Artificial aids, including but not limited to orthopedic shoes, arch supports, elastic stockings, dentures and wigs.
25. Non-medical ancillary services, including but not limited to vocational rehabilitation, behavioral training, and training or education services for learning disabilities, developmental delays, autism or mental retardation.

These Are Only the Highlights

As you can see, the plan is designed to combine in-depth coverage with affordable 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.

“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 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.

Catalog Number: BSF47499

©2002 CIGNA Health Corporation