

City of Dallas

**CIGNA HealthCare of  
Texas, Inc.  
HMO**

FOR MORE INFORMATION OR TO MAKE A COMPLAINT, CALL THE NUMBER ON YOUR ID CARD

This document printed on May 9, 2003,  
takes the place of any documents previously issued to you which described your benefits.



## **IMPORTANT NOTICE**

To obtain information or make a complaint:

You may call CIGNA HealthCare of Texas, Inc.'s toll-free telephone number for information or to make a complaint at:

**1-800-CIGNA24**

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

**1-800-252-3439**

You may write the Texas Department of Insurance:  
P.O. Box 149104  
Austin, TX 78714-9104

FAX # (512) 475-1771

### **PREMIUM OR CLAIM DISPUTES:**

Should you have a dispute concerning your premium or about a claim, you should contact the agent or the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

### **ATTACH THIS NOTICE TO YOUR CONTRACT:**

This notice is for information only and does not become a part or condition of the attached document.

## **AVISO IMPORTANTE**

Para obtener información o para someter una queja:

Usted puede llamar a número de teléfono gratis de CIGNA Healthcare of Texas, Inc.'s para información o para someter una queja al:

**1-800-CIGNA24**

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos o quejas al:

**1-800-252-3439**

Puede escribir al Departamento de Seguros de Texas:  
P.O. Box 149104  
Austin, TX 78714-9104

FAX # (512) 475-1771

### **DISPUTAS SOBRE PRIMAS O RECLAMOS:**

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el agente o la compañía primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

### **UNA ESTE AVISO A SU CONTRATO:**

Este aviso es solo para propósito de información y no se convierte en parte o condición del documento adjunto.



## *Thank you for choosing CIGNA HealthCare!*

Here is your guide to getting the most from your health care plan. It outlines the important benefits of belonging to a CIGNA HealthCare plan, tells you how to use those benefits wisely and should answer most of your questions.

Please keep it for reference.

If you can't find the information that you need, call Member Services at the toll-free number on your CIGNA HealthCare ID card. Or visit our web site, [www.cigna.com](http://www.cigna.com).

We're here to help!



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## Introduction to HMO

### The Benefits of Belonging to a CIGNA HealthCare Plan

Your CIGNA HealthCare plan is designed to help you stay healthy.

As you read through this information, you'll learn more about the covered services, benefits and special programs that help you take better care of yourself.

You choose a Primary Care Physician (PCP) to serve as your personal physician. Your PCP can treat you for a wide variety of conditions, provide preventive care, refer you to specialists and coordinate hospital care when needed. Each covered member of your family can choose his or her own PCP.

Your plan includes:

- Preventive Care – coverage for regular checkups, tests and childhood immunizations through programs tailored to your needs.
- As part of CIGNA HealthCare's commitment to women's health, you can see an OB/GYN in the CIGNA HealthCare network for covered obstetrical and gynecological services without a referral from your PCP. If your PCP is part of a Limited Network, you must choose an OB/GYN within the limited network.
- Prenatal care once your pregnancy is confirmed. You pay only the copayment for the first office visit, the one that confirms you're pregnant. After that, you pay nothing for routine maternity office visits throughout your pregnancy.
- Mental health and substance abuse services. These services require authorization by CIGNA Behavioral Health, Inc., or its affiliates. For information about your mental health and substance abuse services, to access care, or to speak with a behavioral health professional, call the toll-free "mental health and substance abuse" number found on your CIGNA Healthcare ID card. You can call 24 hours a day, 7 days a week.
- 24-hour emergency coverage, worldwide.

- **Access to the CIGNA HealthCare 24-Hour Health Information Line.**<sup>SM</sup> This line is staffed by Registered Nurses who can assist with health related questions at any time of the day or night. Look for the 24-Hour Health Information Line Library at the end of this guide.
- **Guest Privileges** – under certain circumstances, such as when you are temporarily away from your usual service area for at least 60 days, you may be able to obtain coverage in another area where there is a CIGNA HealthCare plan available.

### If You Have a Question

This Introduction briefly summarizes some of the important features of your coverage. For a complete explanation of your coverage please refer to your Group Service Agreement.

### Where to Find More Information

CIGNA HealthCare offers you a variety of ways to learn more about your plan and coverage. We strive to make sure that the answers you need are always close by.

### Your CIGNA HealthCare ID Card

Your CIGNA HealthCare identification (ID) card identifies you as a CIGNA HealthCare member to physicians, hospitals and other health care providers. Show it and you'll receive all of the service and supplies your plan offers as long as you are eligible.

- Carry it with you at all times.
- Show it whenever you receive medical care.
- If you lose your card or if it's stolen, just call Member Services or your employer. We'll send you a replacement right away.
- Each family member covered by your plan, even your children, should have his or her own card. If you need additional cards for family members, just call Member Services.

### Member Services

Member Services answers your questions, finds the information you need and works to resolve your problem quickly.

- The toll-free number is on your CIGNA HealthCare ID card.



- Se habla Español – and most other languages. We have bilingual representatives in Spanish-speaking areas and the AT&T Language Line translates more than 140 other languages.

Call Member Services if:

- Any of your personal or family information changes – name, address, phone number, marital status, employment or number of dependents. Also notify your employer of these changes.
- You have questions about how your plan works, your benefits, or a claim.
- You'd like an updated Physician Directory or more detailed information about a doctor or hospital.
- You want to change your PCP.

### [www.cigna.com](http://www.cigna.com)

Our interactive web site is a valuable source of information. We update it often, so visit it often! You can:

- Find participating physicians, specialists, hospitals, and pharmacies fast. Now available in most areas, our interactive directories do the work. You can also download and print customized directories, even change your PCP online.
- Learn more about your plan and the benefits and programs available to you and your covered family members.
- Visit **YourHealth@CIGNA**<sup>®</sup> to learn about important health care topics. Read online editions of our newsletter for helpful information on personal and family health, diet, exercise and healthy lifestyles.

### The CIGNA HealthCare 24-Hour Health Information Line<sup>SM</sup>

No matter where in the U.S. you are, helpful health information is as close as the nearest phone. Just call the CIGNA HealthCare 24-Hour Health Information Line,<sup>SM</sup> at the toll-free number on your CIGNA HealthCare ID card:

- Speak with registered nurses for answers to your health questions, including questions regarding emergency or urgent care, and get self-care tips

that can help ease the discomfort of an illness or injury.

- Listen to informative, recorded programs on more than 1,000 health topics. The Health Information Library program list is at the end of this guide.
- Listen to as many programs as you like, whenever you like. And you can control all of the playback functions with your phone.

This service is available around the clock, seven days a week.

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## Emergencies

An emergency is a sudden unexpected injury or a serious illness that a prudent layperson (a person with an average knowledge of medical science) believes needs to be treated right away or it could result in loss of life, serious medical complications or permanent impairment. For more information about emergency care, please see "Section IV" in the Group Service Agreement.

What to do in an emergency:

- Don't delay! Get help immediately. Call or ask someone to call 911 or your local emergency service, police or fire department. Or go directly to the nearest emergency facility.
- In an emergency you can go to any emergency facility or hospital, anywhere, even one that is not in the CIGNA HealthCare network.
- You do not need a referral from your PCP for emergency services, but you do need to call your PCP as soon as possible for further assistance and advice on follow-up care. If you require specialty care or a hospital admission, your PCP will coordinate it and handle the necessary authorizations for care or hospitalization.
- You're covered 24 hours a day, seven days a week.
- You will pay only a copayment for covered emergency services; it may be higher than your office visit copayment and it's listed on your CIGNA HealthCare ID card.
- If you are unsure about whether you should seek emergency care you can call your PCP, the physician covering calls for your PCP or the



## CIGNA HealthCare 24-Hour Health Information Line.<sup>SM</sup>

Examples of emergency situations can include:

- Uncontrolled bleeding
- Seizure or loss of consciousness
- Shortness of breath
- Chest pain or severe squeezing sensation in the chest
- Suspected overdose of medication or poisoning
- Sudden paralysis or slurred speech
- Burns
- Cuts
- Broken bones

## Other Medical Care

Situations that are not considered emergencies or do not require urgent care should be handled through a scheduled office visit with your PCP. Examples can include:

- Routine physicals
- Childhood immunizations
- Routine care for chronic conditions
- Follow-up visits to check injuries or broken bones
- Prescription drug needs

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## Urgent Care

You're also covered for situations that aren't emergencies but still require prompt medical attention. Examples can include:

- Severe sore throat
- Sprains and strains
- Ear or eye infection
- Fever in an adult or child

What to do when you need urgent care:

- If possible, call your PCP first. This notifies your doctor of your condition and helps coordinate your care for effective treatment.
- You can also call the CIGNA HealthCare 24-Hour Health Information Line<sup>SM</sup> and ask to speak with a registered nurse about your condition.

Your PCP or the CIGNA HealthCare 24-Hour Health Information Line nurse may recommend steps you can take to be more comfortable and/or schedule an office visit.



## **GROUP SERVICE AGREEMENT**



CIGNA HealthCare

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# I. Definitions of Terms Used In this Group Service Agreement

## Section I. Definitions of Terms Used in This Group Service Agreement

The following definitions will help you in understanding the terms that are used in this Group Service Agreement. As you are reading this Group Service Agreement you can refer back to this section. We have identified defined terms throughout the Agreement by capitalizing the first letter of the term.

### Agreement

This Agreement, the Face Sheet, the Schedule of Copayments, any optional Riders, any other attachments, your Enrollment Application, and any subsequent written amendment or written modification to any part of the Agreement.

### Anniversary Date of Agreement

The date written on the Face Sheet as the Agreement anniversary date.

### Contract Year

The 12-month period beginning at 12:01 a.m. on the first day of the initial term or any renewal term and ending at 12:01 a.m. on the next anniversary of that date.

### Copayment

The amount shown in the schedule of Copayments that you pay at the time that certain covered Services and Supplies are delivered. You are responsible for paying the Copayment at the time services are received.

### Days

Calendar days; not 24 hour periods unless otherwise expressly stated.

### Dependent

An individual in the Subscriber's family who is enrolled as a Member under this Agreement. You must meet the Dependent eligibility requirements in "Section II. Enrollment and Effective Date of Coverage" to be eligible to enroll as a Dependent.

### Emergency Services

Emergency Services are defined in "Section IV. Covered Services and Supplies."

### Enrollment Application

The enrollment process that must be completed by an eligible individual in order for coverage to become effective.

### Face Sheet

The part of this Agreement that contains certain provisions affecting the relationship between the Healthplan and the Group. You can get a copy of the Face Sheet from the Group.

### Group

The employer, labor union, trust, association, partnership, government entity, or other organization listed on the Face Sheet to this Agreement which enters into this Agreement and acts on behalf of Subscribers and Dependents who are enrolled as Members in the Healthplan.

### Healthplan

The CIGNA HealthCare health maintenance organization (HMO) which is organized under applicable law and is listed on the Face Sheet to this Agreement. Also referred to as "we", "us" or "our".

### Healthplan Medical Director

A Physician charged by the Healthplan to assist in managing the quality of the medical care provided by Participating Providers in the Healthplan; or his designee.

### Limited Network

A network or association of health professionals who work together to provide a full range of health care services. If the Primary Care Physician is selected from a Limited Network, then all care, including specialty and hospital, will be provided by or arranged for within the network to which the Primary Care Physician belongs. Limited Networks may be delegated Utilization Management, Credentialing and Claims Processing functions.

### Medical Services

Professional services of Physicians or Other Participating Health Professionals (except as limited or excluded by this Agreement), including medical, psychiatric, surgical, diagnostic, therapeutic, and preventive services.



# I. Definitions of Terms Used In this Group Service Agreement

## Medically Necessary/Medical Necessity

Medically necessary covered Services and Supplies are those Services and Supplies that are determined by the Healthplan Medical Director to be:

- required to meet your essential health needs; and
- consistent with the diagnosis of the condition for which they are required; and
- consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research; and
- required for purposes other than the convenience of the Provider or the comfort and convenience of the patient; and
- rendered in the least intensive setting that is appropriate for the delivery of health care.

## Member

An individual meeting the eligibility criteria as a Subscriber or a Dependent who is enrolled for Healthplan coverage and for whom all required Prepayment Fees have been received by the Healthplan. Also referred to as “you” or “your”.

## Membership Unit

The unit of Members made up of the Subscriber and his Dependent(s).

## Open Enrollment Period

The period of time established by the Healthplan and the Group as the time when Subscribers and their Dependents may enroll for coverage. The Open Enrollment Period occurs at least once every Contract Year and will last for at least one full calendar month of thirty-one (31) days.

## Other Participating Health Care Facility

Other Participating Health Care Facilities are any facilities other than a Participating Hospital or hospice facility that is operated by or has an agreement to render services to Members. Examples of Other Participating Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation hospitals and sub-acute facilities.

## Other Participating Health Professional

An individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver Medical Services and who has an agreement with the Healthplan to provide Services and Supplies to Members. Other Participating Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses.

## Participating Hospital

An institution licensed as an acute care hospital under the applicable state law, which has an agreement to provide hospital services to Members.

## Participating Physician

A Primary Care Physician (PCP) or other Physician who has an agreement to provide Medical Services to Members.

## Participating Provider

Participating Providers are Participating Hospitals, Participating Physicians, Other Participating Health Professionals, and Other Participating Health Care Facilities.

## Physician

An individual who is qualified to practice medicine under the applicable state law (or a partnership or professional association of such people) and who is a licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.).

## Prepayment Fee

The sum of money paid to the Healthplan by the Group in order for you to receive the Services and Supplies covered by this Agreement.

## Primary Care Physician (PCP)

A Physician who practices general medicine, family medicine, internal medicine or pediatrics who, through an agreement with the Healthplan, provides basic health care services to you if you have chosen him as your Primary Care Physician (PCP). Your Primary Care Physician (PCP) also arranges specialized services for you.



# I. Definitions of Terms Used In this Group Service Agreement

## Primary Plan

The Plan that determines and provides or pays its benefits without taking into consideration the existence of any other Plan.

## Prior Authorization

The approval a Participating Provider must receive from the Healthplan Medical Director, prior to services being rendered, in order for certain Services and Supplies to be covered under this Agreement.

## Referral

The approval you must receive from your PCP in order for the services of a Participating Provider, other than the PCP, or participating OB/GYN to be covered.

## Rider

An addendum to this Agreement between the Group and the Healthplan.

## Schedule of Copayments

The section of this Agreement that identifies applicable Copayments and maximums.

## Service Area

The geographic area, as described in the Provider Directory applicable to your plan, where the Healthplan is authorized to provide services.

## Services and Supplies

Those Medically Necessary Services and Supplies described in "Section IV. Covered Services and Supplies."

## Subscriber

An employee or participant in the Group who is enrolled as a Member under this Agreement. You must meet the requirements contained in "Section II. Enrollment and Effective Date of Coverage" to be eligible to enroll as a Subscriber.

## Total Copayment Maximums

The total amount of Copayments that an individual Member or Membership Unit must pay within a Contract Year. When the individual Member or Membership Unit has paid applicable Copayments

up to the Total Copayment Maximums, that Member or Membership Unit will not be required to pay Copayments for those Services and Supplies for the remainder of the Contract Year. The Total Copayment Maximums and the Copayments that apply toward these maximums are identified in the Schedule of Copayments.

## Urgent Care

Urgent Care is defined in "Section IV. Covered Services and Supplies."

## We/Us/Our

CIGNA HealthCare of Texas, Inc.

## You/Your

The Subscriber and/or any of his Dependents.

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## II. Enrollment and Effective Date of Coverage

### Section II. Enrollment and Effective Date of Coverage

#### Who Can Enroll as a Member

To be eligible for covered Services and Supplies you must be enrolled as a Member. To be eligible to enroll as a Member you must meet either the Subscriber or Dependent eligibility criteria listed below. You must also meet and continue to meet the Group-specific enrollment and eligibility rules on the Face Sheet.

#### A. To be eligible to enroll as a Subscriber, you must:

1. be an employee of the Group or a participant in the Group; and
2. live, reside or work in the Service Area; and
3. meet and continue to meet these criteria.

#### B. To be eligible to enroll as a Dependent, you must:

1. be the legal spouse of the Subscriber and you must live, reside or work in the Service Area; or
2. be the natural child, step-child, or adopted child of the Subscriber; or the child for whom the Subscriber is the legal guardian, or the child who is the subject of a lawsuit for adoption by the Subscriber, if the Subscriber has the legal responsibility for the health of the child, or the child supported pursuant to a court order imposed on the Subscriber (including a qualified medical child support order) or a grandchild of the Subscriber who is also a dependent of the Subscriber for federal income tax purposes, provided that the child:
  - a. is unmarried and legally dependent upon the Subscriber for support;
  - b. resides in the Service Area (unless the child is a full-time registered student outside the Service Area or is covered under a Qualified Child Medical Support Order) or lives with the Subscriber who lives outside the Service Area (but works within the Service Area) and

- i. has not yet reached age twenty-five (25); or
- ii. the child is twenty-five (25) or older and incapable of self-sustaining support because of mental retardation or a physical handicap which existed prior to attaining twenty-five (25) years of age. You must submit proof of the child's condition and dependence to us within thirty-one (31) days after the date the child ceases to qualify as a Dependent under subsection (i) above. We may, from time to time, require proof of the continuation of the child's condition and dependence. We may require such proof only once a year.

A Subscriber's grandchild is eligible for coverage if the grandchild resides with the Subscriber and is dependent upon the Subscriber, in accordance with federal income tax guidelines, at the time the application for coverage is made.

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### Enrollment and Effective Date of Coverage

#### A. Enrollment during an Open Enrollment Period

If you meet the Subscriber or Dependent eligibility criteria, you may enroll as a Member during the Open Enrollment Period by submitting a completed Enrollment Application, together with any applicable fees, to the Group.

If enrolled during the Open Enrollment Period, your effective date of coverage is the first day of the Contract Year.

#### B. Enrollment after an Open Enrollment Period

1. If, after the Open Enrollment Period, you become eligible for coverage as a Subscriber or a Dependent, you may enroll as a Member within thirty-one (31) days of the day on which you met the eligibility criteria. To enroll, you must submit an Enrollment Application, together with any additional fees due, to the Group. If so enrolled, your



## II. Enrollment and Effective Date of Coverage

effective date of coverage will be the day on which you meet the eligibility criteria.

If you do not enroll within the thirty-one (31) days, your next opportunity to enroll will be during the next Open Enrollment Period.

2. If you are a Subscriber who is enrolled as a Member, you may enroll a newborn child prior to the birth of the child or within thirty-one (31) days after the child's birth. Newborn children of the Subscriber are covered for the first thirty-one (31) days after birth. To enroll a newborn child, you must submit an Enrollment Application, together with any additional fees due, to the Group. If so enrolled, the effective date of coverage for your newborn child will be the date of his birth.

If you do not enroll a newborn child within the thirty-one (31) days, coverage will end at the end of the first thirty-one (31) days and your next opportunity to enroll the child will be during the next Open Enrollment Period.

3. If you are a Subscriber who is enrolled as a Member, you may enroll an adopted child or child for whom you have been granted legal guardianship within thirty-one (31) days of the date the child is legally placed with you for adoption or within thirty-one (31) days of the date you are granted legal guardianship. To enroll an adopted child or a child for whom you are the legal guardian, you must submit an Enrollment Application, together with any additional fees due, to the Group. If so enrolled, the effective date of coverage for your child will be the date of legal placement of the child for adoption or the date of court ordered legal guardianship.

If you do not enroll an adopted child or a child for whom you are legal guardian within the thirty-one (31) days, your next opportunity to enroll the child will be during the next Open Enrollment Period.

### C. Special Enrollment After Open Enrollment Period

There are special circumstances under which an individual who was eligible to enroll for coverage as a Subscriber, but did not do so, may

be eligible to enroll himself and any eligible Dependents outside of the Open Enrollment Period.

After the Open Enrollment Period, you may submit an Enrollment Application and any applicable fees, to the Group, for yourself and any eligible Dependent(s) within thirty-one (31) days of the date of the following events:

1. Marriage;
2. Birth of a dependent newborn child; or
3. Adoption of a dependent child or legal placement of a child for adoption.

If so enrolled, the effective date of coverage will be the day of the event creating eligibility.

If you do not enroll within the thirty-one (31) days of one of these events, the next opportunity for you and any eligible Dependents to enroll will be during the next Open Enrollment Period.

### D. Enrollment Due to Loss of Prior Creditable Coverage

If you and/or your Dependent(s) did not enroll as a Member during the Open Enrollment Period because you and/or your Dependent(s) had other creditable health care coverage, you may be eligible to enroll for coverage under this plan if you later lose that coverage. You must submit to the Group an Enrollment Application, and any applicable fees due within thirty-one (31) days of the day that you or your Dependent(s):

1. are no longer eligible for the other coverage for any reason (including separation, divorce or death of the Subscriber);
2. lost the other coverage because an employer or plan sponsor failed to pay required premium or fees; or
3. completed continuation of other coverage as provided under federal or state law.

If so enrolled, the effective date of coverage will be the first day of the month following the day on which the Healthplan received the Enrollment Application.

If these conditions are not met, or if you do not submit an Enrollment Application within thirty-one (31) days of one of these events, the next opportunity for you and any eligible



## II. Enrollment and Effective Date of Coverage

Dependent(s) to enroll will be during the next Open Enrollment Period.

### E. Full and Accurate Completion of Enrollment Application

Each Subscriber must fully and accurately complete the Enrollment Application. You represent that all information shown in such applications shall be true, correct and complete to the best of your knowledge and belief. All rights and benefits hereunder are subject to the condition that such information shall be true, correct and complete. False, incomplete or misrepresented information provided in any Enrollment Application may, in the Healthplan's sole discretion, cause the coverage of the Subscriber and/or his Dependents to be null and void from its inception. A statement will not be used in a contest to void, cancel or non-renew your coverage or to reduce benefits unless:

1. the statement is in a copy of the Enrollment Application; and
2. a signed copy of the Enrollment Application is or has been furnished to you or your representative.

Coverage will only be contested because of fraud or intentional misrepresentation of a material fact on an Enrollment Application.

### F. Hospitalization on the Effective Date of Coverage

If you are confined in a hospital on the effective date of your coverage, you must notify us of such a hospitalization within two (2) days, or as soon as reasonably possible thereafter. When you become a Member of the Healthplan, you agree to permit the Healthplan to assume direct coordination of your health care. We reserve the right to transfer you to the care of a Participating Provider and/or Participating Hospital if the Healthplan Medical Director, in consultation with your attending Physician, determines that it is medically safe to do so.

If you are hospitalized on the effective date of coverage and you fail to notify us of this hospitalization, refuse to permit us to coordinate your care, or refuse to be transferred to the care of a Participating Provider or Participating Hospital, we will not be obligated to pay for any

medical or hospital expenses that are related to your hospitalization following the first two (2) days after your coverage begins.

### G. To be eligible to enroll as a Member, you must:

1. never have been terminated as a Member of any CIGNA HealthCare Healthplan for any of the reasons explained in the "Termination For Cause" provision of "Section VII. Termination of Your Coverage" and
2. not have any unpaid financial obligations to the Healthplan or any other CIGNA HealthCare Healthplan.

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## III. Agreement Provisions

### Section III. Agreement Provisions

#### A. Healthplan's Representations and Disclosures

1. The Healthplan is a for-profit health maintenance organization (HMO) which arranges for the provision of covered Services and Supplies through a network of Participating Providers. The list of Participating Providers is provided to all Members at enrollment without charge. If you would like another list of Participating Providers, please contact Member Services at the toll-free number found on your CIGNA HealthCare ID card or visit the CIGNA HealthCare web site at [www.cigna.com/healthcare](http://www.cigna.com/healthcare).
2. With the exception of any employed Physicians who work in a facility operated by the Healthplan (so-called "staff model" providers), the Participating Providers are independent contractors. They are not the agents or employees of the Healthplan and they are not under the control of the Healthplan or any CIGNA company. All Participating Providers are required to exercise their independent medical judgment when providing care.
3. The Healthplan maintains all medical information concerning a Member as confidential in accordance with applicable laws and professional codes of ethics. A copy of the Healthplan's confidentiality policy is available upon request.
4. We do not restrict communication between Participating Providers and Members regarding treatment options.
5. Under federal law (the Patient Self-Determination Act), you may execute advance directives, such as living wills or a durable power of attorney for health care, which permit you to state your wishes regarding your health care should you become incapacitated.
6. Upon your admission to a participating inpatient facility, a Participating Physician other than your PCP may be asked to direct and oversee your care for as long as you are in the inpatient facility. This Participating

Physician is often referred to as an "inpatient manager" or "hospitalist." The decision regarding whether or not to utilize a hospitalist is between you and your PCP. Usage of a hospitalist is not required under your plan.

7. The terms of this Agreement may be changed in the future either as a result of an amendment agreed upon by the Healthplan and the Group or to comply with changes in law. The Group or the Healthplan may terminate this Agreement as specified in this Agreement. In addition, the Group reserves the right to discontinue offering any plan of coverage.

#### 8. Choosing a Primary Care Physician

When you enroll as a Member, you choose a Primary Care Physician (PCP). Each covered Member of your family also chooses a PCP. Your PCP is your personal doctor and serves as your health care manager. If you do not select a PCP, we will assign one for you. If your PCP leaves the CIGNA HealthCare network, you will be able to choose a new PCP. You may voluntarily change your PCP for other reasons but not more than once in any calendar month. We reserve the right to determine the number of times during a Contract Year that you will be allowed to change your PCP. You will not be limited to any less than four (4) times in any Contract Year. If you select a new PCP before the fifteenth day of the month, the designation will be effective on the first day of the month following your selection. If you select a new PCP on or after the fifteenth day of the month, the designation will be effective on the first day of the month following the next full month. For example, if you notify us on June 10, the change will be effect on July 1. If you notify us on June 15, the change will be effective on August 1.

Your choice of a PCP may affect the specialists and facilities from which you may receive services. Your choice of a specialist may be limited to specialists in your PCP's medical group or network,



### III. Agreement Provisions

including a Limited Network. Therefore, you may not have access to every specialist or Participating Provider in your Service Area. Before you select a PCP, you should check to see if that PCP is associated with the specialist or facility you prefer to use. If the Referral is not possible, you should ask the specialist or facility about which PCPs can make Referrals to them, and then verify the information with the PCP before making your selection.

#### 9. Specialists as Primary Care Physicians

If you have a chronic disabling or life-threatening illness, you may apply to the Healthplan Medical Director to request that your treating specialist become the coordinator of all of our care. Your specialist must agree to:

- become the coordinator of all of your care;
- meet and accept all of our requirements and payment schedules for Primary Care Physicians; and
- sign your request

If you are not satisfied with the Healthplan Medical Director's response to your request, you may appeal the response as provided in "subsection C. When You Have a Complaint or an Appeal of an Adverse Determination."

#### 10. Services by Non-Participating Providers

If you need covered services and our Participating Provider network does not contain a Participating Provider with the specialty necessary to treat you, your Participating Physician may request a referral to a non-Participating Provider who will be reimbursed at the prevailing Participating Provider rate or at a rate agreed upon between us and the non-Participating Provider. The Healthplan Medical Director has the right to refer you to a non-Participating Provider of his choice or to deny the request for referral if he feels that the services can be adequately provided by a Participating Provider. The Healthplan Medical Director may not make any denials unless a provider of the same or similar

specialty has reviewed the request for referral.

#### 11. Referrals to Specialists

You must obtain a Referral from your PCP before visiting any provider other than your PCP in order for the visit to be covered. The Referral authorizes the specific number of visits that you may make to a provider within a specified period of time. If you receive treatment from a provider other than your PCP without a Referral from your PCP, the treatment is not covered.

##### Exceptions to the Referral process:

If you are a female Member, you may visit a qualified Participating Provider for covered obstetrical and gynecological services, as defined in "Section IV. Covered Services and Supplies," without a Referral from your PCP.

Care and treatment by an Acupuncturist is available without a Referral only to the extent that the services performed by the Acupuncturist are not excluded in general.

You do not need a Referral from your PCP for Emergency Services as defined in the "Section IV. Covered Services and Supplies." In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. You do not need a Referral from your PCP for Emergency Services, but you do need to call your PCP as soon as possible for further assistance and advice on follow-up care. If you require specialty care or a hospital admission, your PCP will coordinate it and handle the necessary authorizations for care or hospitalization.

In an emergency, you should seek immediate medical attention and then as soon as possible thereafter you need to call your PCP for further assistance and advice on follow-up care. If you require specialty care or a hospital admission, your PCP will coordinate it and handle the necessary authorization for care or hospitalization.



### III. Agreement Provisions

In an Urgent Care situation a Referral is not required but you should, whenever possible, contact your PCP for direction prior to receiving services.

#### 11. Continuity of Treatment

We will give you reasonable written notice of the impending termination of a Participating Provider who you are currently under treatment with.

If you are receiving treatment from a Participating Provider at the time the Participating Provider agreement is terminated, for reasons other than medical incompetence or professional misconduct, you may be eligible for up to ninety days of continued care with that provider. To be eligible for this continued care you must be receiving treatment in accordance with the dictates of medical prudence for (a) a disability; (b) an acute condition; (c) a life threatening illness or (d) for pregnancy past the twenty fourth (24<sup>th</sup>) week, and your treating provider reasonably believes that discontinuing your care with him may cause you harm. Your provider must identify your special circumstance to the Healthplan Medical Director and request that you continue under his care. Your provider must agree not to seek payments from you except for Copayments. The Healthplan Medical Director may deny this request if he determines that your treatment may be transferred to another provider without causing you harm or if he determines that the request is not Medically Necessary.

#### 12. Provider Compensation

We compensate our Participating Providers in ways that are intended to emphasize preventive care, promote quality of care, and assure the most appropriate use of Medical Services. You can discuss with your provider how he is compensated by us. The methods we use to compensate Participating Providers are:

Discounted fee for service – payment for service is based on an agreed upon discounted amount for the services provided.

Capitation – Physicians, provider groups and Physician/hospital organizations are paid a fixed amount at regular intervals for each Member assigned to the Physician, provider group or Physician/hospital organization, whether or not services are provided. This payment covers Physician and/or, where applicable, hospital or other services covered under the benefit plan. Medical groups and Physician/hospital organizations may in turn compensate providers using a variety of methods.

Capitation offers health care providers a predictable income, encourages Physicians to keep people well through preventive care, eliminates the financial incentive to provide services that will not benefit the patient, and reduces paperwork.

Providers paid on a “capitated” basis may participate with us in a risk sharing arrangement. They agree upon a target amount for the cost of certain health care services, and they share all or some of the amount by which actual costs are over target. Provider services are monitored for appropriate utilization, accessibility, quality and Member satisfaction.

We may also work with third parties who administer payments to Participating Providers. Under these arrangements, we pay the third party a fixed monthly amount for these services. Providers are compensated by the third party for services provided to Healthplan participants from the fixed amount. The compensation varies based on overall utilization.

Salary – Physicians and other providers who are employed to work in our medical facilities are paid a salary. The compensation is based on a dollar amount, decided in advance each year, that is guaranteed regardless of the services provided. Physicians are eligible for any annual bonus based on quality of care, quality of service and appropriate use of Medical Services.

Bonuses and Incentives – Eligible Physicians may receive additional payments based on their performance. To determine



### III. Agreement Provisions

who qualifies, we evaluate Physician performance using criteria that may include quality of care, quality of service, accountability and appropriate use of Medical Services.

Per Diem – A specific amount is paid to a hospital per day for all health care received. The payment may vary by type of service and length of stay.

Case Rate – A specific amount is paid for all the care received in the hospital for each standard service category as specified in our contract with the provider (e.g., for a normal maternity delivery).

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#### B. Member’s Rights, Responsibilities and Representations

##### You have the right to:

1. Medical treatment that is available when you need it and is handled in a way that respects your privacy and dignity.
2. Get the information you need about your health care plan, including information about services that are covered, services that are not covered, and any costs that you will be responsible for paying.
3. Have access to a current list of providers in our network and have access to information about a particular provider’s education, training and practice.
4. Select a Primary Care Physician (PCP) for yourself and each covered Member of your family, and to change your PCP for any reason.
5. Have your medical information kept confidential by our employees and your health care provider. Confidentiality laws and professional rules of behavior allow us to release medical information only when it’s required for your care, required by law, necessary for the administration of your plan or to support our programs or operations that evaluate quality and service. We may also summarize information in reports that do not identify you or any other participants specifically.

6. Have your health care provider give you information about your medical condition and your treatment options, regardless of benefit coverage or cost. You have the right to receive this information in terms you understand.
7. Learn about any care you receive. You should be asked for your consent to all care unless there is an emergency and your life and health are in serious danger.
8. Refuse medical care. If you refuse medical care, your health care provider should tell you what might happen. We urge you to discuss your concerns about care with your PCP or another Participating Physician. Your doctor will give you advice, but you will always have the final decision.
9. Be heard. Our complaint-handling process is designed to hear and act on your complaint or concern about us and/or the quality of care you receive, provide a courteous, prompt response, and to guide you through our appeals process if you do not agree with our decision.

##### You have the responsibility to:

1. Review and understand the information you receive about your health care plan. Please call CIGNA HealthCare Member Services when you have questions or concerns.
2. Understand how to obtain covered Services and Supplies that are provided under your plan.
3. Show your CIGNA HealthCare ID card before you receive care.
4. Schedule a new patient appointment with any new CIGNA HealthCare PCP; build a comfortable relationship with your doctor; ask questions about things you don’t understand; and follow your doctor’s advice. You should also understand that your condition may not improve and may even get worse if you don’t follow your doctor’s advice.
5. Provide honest, complete information to the providers caring for you.



### III. Agreement Provisions

6. Know what medicine you take, why, and how to take it.
7. Pay all Copayments for which you are responsible at the time the service is received.
8. Keep scheduled appointments and notify the doctor's office ahead of time if you are going to be late or miss an appointment.
9. Pay all charges for missed appointments and for services that are not covered by your plan.
10. Voice your opinions, concerns or complaints to CIGNA HealthCare Member Services and/or your provider.
11. Notify your employer as soon as possible about any changes in family size, address, phone number or membership status.

**You represent that:**

1. The information provided to us and the Group in the Enrollment Application is complete and accurate.
2. By enrolling in the Healthplan, you accept and agree to all terms and conditions of this Agreement.
3. By presenting your CIGNA HealthCare ID card and receiving treatment and services from our Participating Providers, you authorize the following to the extent allowed by law:
  - a. any provider to provide us with information and copies of any records related to your condition and treatment;
  - b. any person or entity having confidential information to provide any such confidential information upon request to us, any Participating Provider, and any other provider or entity performing a service, for the purpose of administration of the plan, the performance of any Healthplan program or operations, or assessing or facilitating quality and accessibility of health care Services and Supplies;
  - c. us to disclose confidential information to any persons, company or entity to the

extent we determine that such disclosure is necessary or appropriate for the administration of the plan, the performance of the Healthplan programs or operations, assessing or facilitating quality and accessibility of healthcare Services and Supplies, or reporting to third parties involved in plan administration; and

- d. that payment be made under Part B of Medicare to us for medical and other services furnished to you for which we pay or have paid, if applicable.

This authorization will remain in effect until you send us a written notice revoking it or for such shorter period as required by law. Until revoked, we and other parties may rely upon this authorization.

With respect to Members, confidential information includes any medical, dental, mental health, substance abuse, communicable disease, AIDS and HIV related information and disability or employment related information.

4. You will not seek treatment as a CIGNA HealthCare Member once your eligibility for coverage under this Agreement has ceased.

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**C. When You Have A Complaint or an Appeal of an Adverse Determination**

(For the purposes of this section, any reference to "you", "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.)

We want you to be completely satisfied with the Healthplan and the care you receive. That's why we've established a process for addressing your concerns and solving your problems.

**Complaint Process**

We're here to listen and help. If you have a complaint regarding dissatisfaction about any aspect of the Healthplan's operation including, but not limited to dissatisfaction with plan administration, procedures, denial, reduction, or termination of a service for reasons not related to Medical Necessity; disenrollment decisions;



## III. Agreement Provisions

or the way a service is provided, you can call the toll-free number on your CIGNA HealthCare ID card and explain your situation to one of our Member Services representatives. You can also express that concern by walk-in interview, arranged appointment, or in writing at the following:

CIGNA HealthCare of Texas, Inc.  
Two Riverway, Suite 1200, Houston, TX 77056  
Healthplan Toll-Free Number appears on your  
CIGNA HealthCare ID card

A complaint does not include (a) a misunderstanding or problem of misinformation that can be promptly resolved by the Healthplan by clearing up the misunderstanding or by supplying the correct information to your satisfaction; or (b) you or your provider's dissatisfaction or disagreement with an Adverse Determination.

If you notify us orally or in writing of your complaint, no later than the 5th business day after we receive your complaint, we will send you a letter acknowledging the date on which your complaint was received. If you notify us of your complaint orally, we will send you a one-page complaint form that you must return to us for prompt resolution of the complaint.

We'll get back to you with a decision in writing, as soon as possible, but in any case within thirty (30) calendar days after we receive your complaint.

You may request that the Complaint Process be expedited, if: (a) the time frames under this Complaint Process would seriously jeopardize your life, health, or ability to regain maximum functionality or, in the opinion of your treating physician, would cause you severe pain, which cannot be managed without the requested services; or (b) your complaint involves non-authorization of an admission or continuing hospital stay. The Healthplan Medical Director, in consultation with your treating physician, will decide if an expedited appeal is necessary. When a complaint is expedited, we will respond orally with a decision within one (1) business day, but in no case, not more than seventy-two (72) hours from your request. We will follow up in writing within two (2) calendar days.

If you are not satisfied with the resolution decision, you can start the Complaint Appeals procedure.

### Complaint Appeals Procedures

If we do not resolve your complaint to your satisfaction, you have the right to appeal our decision to our complaint appeal panel. You may appeal by appearing in person before the complaint appeal panel or presenting a written appeal to the complaint appeal panel. When you appeal your complaint:

- (1) We will send an acknowledgment letter to you within five (5) business days after the date we receive your request for an appeal.
- (2) We will appoint members to the complaint appeal panel, which advises us on the resolution of the appeal. The complaint appeal panel will include an equal number of our staff, physicians or other providers and enrollees, who would not have been involved previously with your complaint.
- (3) We will notify you of the outcome of the appeals process no later than the 30th calendar day after we receive your request for appeal.

You may request that the Complaint Appeal Process be expedited, if: (a) the time frames under this Complaint Appeal Process would seriously jeopardize your life, health, or ability to regain maximum functionality or, in the opinion of your treating physician, would cause you severe pain, which cannot be managed without the requested services; or (b) your complaint involves non-authorization of an admission or continuing hospital stay. The Healthplan Medical Director, in consultation with your treating physician, will decide if an expedited appeal is necessary. When a complaint appeal is expedited, we will respond orally with a decision within one (1) business day, but in no case, not more than seventy-two (72) hours from your request. We will follow up in writing within two (2) calendar days.

If you are dissatisfied with the Healthplan's decision of your appeal, you may file a complaint with the Texas Department of



### III. Agreement Provisions

Insurance. Send it in writing to P.O. Box 149091, Austin, Texas 78714-9104 or by calling 800-252-3439.

#### Adverse Determination Appeals

An Adverse Determination is a decision that is made by the Healthplan that the health care services furnished or proposed to be furnished to you are not medically necessary or appropriate. An Adverse Determination also includes a denial by the Healthplan of a request to cover a specific prescription drug prescribed by your physician.

If you are not satisfied with the Adverse Determination, you may appeal the Adverse Determination orally or in writing. We will acknowledge our receipt of your Adverse Determination Appeal in writing within five (5) business days after we receive your Adverse Determination Appeal. If you notify us orally of your Adverse Determination Appeal, we will send you a one-page Adverse Determination Appeal form, which you must return to us for prompt resolution of the Adverse Determination Appeal.

Your appeal of an Adverse Determination will be reviewed and the decision made by a healthcare professional not involved in the initial decision. We will respond in writing with a decision within thirty (30) days after we receive the appeal.

You may request that the Adverse Determination Appeal Process be expedited, if:

- (a) the time frames under this Adverse Determination Appeal Process would seriously jeopardize your life, health, or ability to regain maximum functionality or, in the opinion of your treating physician, would cause you severe pain, which cannot be managed without the requested services; or
- (b) the Adverse Determination involves non-authorization of an admission or continuing hospital stay. The Healthplan Medical Director, in consultation with your treating physician, will decide if an expedited appeal is necessary. When an Adverse Determination Appeal is expedited, we will respond orally with a decision within one (1) business day, but in no case, not more than seventy-two (72) hours from your request. We

will follow up in writing within two (2) calendar days.

#### Voluntary Specialty Review of Adverse Determination Appeals

Your treating physician may request in writing from the Healthplan Medical Director a Voluntary Specialty Review within ten (10) days of the Adverse Determination Appeal decision letter. The Voluntary Specialty Review will be conducted by a health care provider in the same or similar specialty as typically manages the medical or dental condition, procedure or treatment under discussion for review of the Adverse Determination Appeal. The specialist's review will be completed and a response will be sent in writing within fifteen (15) business days of the request. If the specialist upholds the initial adverse determination and you remain dissatisfied, you are still eligible to request a review by an Independent Review Organization.

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#### Independent Review Procedure

If you are not fully satisfied with the decision of the Adverse Determination Appeal Process or the Voluntary Specialty Review, you may request that your appeal be referred to an Independent Review Organization. You may also request that your appeal be referred to an Independent Review Organization if you feel your condition is life threatening. Complaint Appeals are not eligible for the Independent Review Procedure. The Independent Review Organization is composed of persons who are not employed by CIGNA HealthCare or any of its affiliates, and the Independent Review Organization is completely separate from the Healthplan. The Texas Department of Insurance oversees the Independent Review Procedure. A decision to use the Independent Review Procedure will not affect your rights to any other benefits under the plan.

There is no charge to initiate the Independent Review process. The Healthplan will provide you and your treating physician with the necessary forms to request an Independent Review. If your condition is life threatening, you may contact the Healthplan by telephone to initiate the Independent Review Process. The



### III. Agreement Provisions

Healthplan will abide by the decision of the Independent Review Organization.

#### Right to Contact the State of Texas

You have the right to contact the Texas Department of Insurance (TDI) for assistance with your Complaint or with an Appeal of an Adverse Determination at any time. You may also contact TDI if you do not believe the Healthplan has complied with Texas regulations regarding the handling of Complaints or Appeals of Adverse Determination. The Texas Department of Insurance may be contacted at the following address and telephone number:

Texas Department of Insurance  
333 Guadalupe Street  
P.O. Box 149104  
Austin, Texas 78714-9104  
800-252-3439 (telephone)  
512-475-1771 (facsimile)

[www.TDI.state.tx.us](http://www.TDI.state.tx.us) (e-mail)

#### Contents of Complaint, Complaint Appeals and Adverse Determination Appeals Notices

Every notice of a Complaint, Complaint Appeals or an Adverse Determination Appeals decision will be provided in writing or electronically and will include: (1) the specific medical or contractual reason or reasons for the denial decision; (2) the specialty of any physician or health care provider consulted in making the denial decision; (3) reference to the specific plan provisions on which the decision is based; (4) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (5) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a) if the plan is governed by ERISA; (6) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the Complaint, Complaint Appeals or Adverse Determination Appeal decision, including an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other

similar exclusion or limit; and (7) instructions for filing complaints with the Texas Department of Insurance.

If your plan is governed by ERISA, you also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

In most instances, you may not initiate a legal action against the Healthplan until you have completed the Complaint or Adverse Determination Appeal processes. If your Complaint or Adverse Determination Appeal is expedited, there is no need to complete the Complaint or Adverse Determination Appeal process prior to bringing legal action.

#### Relevant Information

Relevant Information is any document, record, or other information which was (a) relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

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#### Arbitration

Any controversy between the Healthplan and the Group, or a Member (including any legal representative acting on behalf of a Member), arising out of or in connection with this Agreement may be submitted to arbitration upon written agreement between both parties. Such



## III. Agreement Provisions

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arbitration shall be governed by the provisions of Texas Arbitration Act, Texas Civil Practice and Remedies Code Section 171.001 et. seq. Regarding cases of medical necessity determination, arbitration will not be imposed prior to a review by an Independent Review Organization (IRO), as provided for under Texas law.

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## IV. Covered Services and Supplies

### Section IV. Covered Services And Supplies

The covered Services and Supplies available to Members under this plan are described below. Any applicable Copayments or limits are identified in the Schedule of Copayments.

Unless otherwise authorized in writing by the Healthplan Medical Director, covered Services and Supplies are available to Members only if:

- They are Medically Necessary and not specifically excluded in this Section or in Section V.
- Provided by your Primary Care Physician (PCP) or if your PCP has given you a Referral, by another Participating Provider. However, “Emergency Services” do not require a Referral from your PCP and do not have to be provided by Participating Providers. Also, you do not need a Referral from your PCP for “Obstetrical and Gynecological Services,” and “Urgent Care.”
- Prior Authorization is obtained from the Healthplan Medical Director by the Participating Provider, for those services that require Prior Authorization. Services that require Prior Authorization include, but are not limited to, inpatient hospital services, inpatient services at any Other Participating Health Care Facility, outpatient facility services, magnetic resonance imaging, non-emergency ambulance, and organ transplant services.

#### Physician Services

All diagnostic and treatment services provided by Participating Physicians and Other Participating Health Professionals, including office visits, periodic health assessments, well-child care and routine immunizations provided in accordance with accepted medical practices, hospital care, consultation, and surgical procedures.

#### Inpatient Hospital Services

Inpatient hospital services for evaluation or treatment of conditions that cannot be adequately treated on an ambulatory basis or in an Other Participating Health Care Facility. Inpatient hospital services include semi-private room and board; care and services in an intensive care unit; drugs,

medications, biologicals, fluids, blood and blood products, and chemotherapy; special diets; dressings and casts; general nursing care; use of operating room and related facilities; laboratory and radiology services and other diagnostic and therapeutic services; anesthesia and associated services; inhalation therapy; radiation therapy; and other services which are customarily provided in acute care hospitals. Inpatient Hospital Services for the treatment of breast cancer will be covered for a minimum of : (1) 48 hours following a mastectomy; and (2) 24 hours following a lymph node dissection.

#### Outpatient Facility Services

Services provided on an outpatient basis, including: diagnostic and/or treatment services; administered drugs, medications, fluids, biologicals, blood and blood products; inhalation therapy; and procedures which can be appropriately provided on an outpatient basis, including certain surgical procedures, anesthesia, and recovery room services.

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#### Emergency Services and Urgent Care

**Emergency Services Both In and Out of the Service Area.** In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. You do not need a Referral from your PCP for Emergency Services, but you do need to call your PCP as soon as possible for further assistance and advice on follow-up care. If you require specialty care or a hospital admission, your PCP will coordinate it and handle the necessary authorizations for care or hospitalization. Participating Providers are on call twenty-four (24) hours a day, seven (7) days a week, to assist you when you need Emergency Services.

If you receive Emergency Services outside the Service Area, you must notify us as soon as reasonably possible. We may arrange to have you transferred to a Participating Provider for continuing or follow-up care if it is determined to be medically safe to do so.

Emergency Services are defined as the medical, psychiatric, surgical, hospital and related health care services and testing, including ambulance service,



## IV. Covered Services and Supplies

which are required to treat a sudden unexpected onset of a bodily injury or a serious illness which could reasonably be expected by a prudent layperson to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, serious disfigurement or, in the case of a pregnancy, serious jeopardy to the health of the fetus in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts, and broken bones.

Emergency Services include any medical screening examination or other evaluation required by state or federal law that is necessary to determine whether an emergency medical condition exists and the necessary emergency care services provided for the treatment and stabilization of an emergency medical condition.

**Urgent Care Inside the Service Area.** For Urgent Care inside the Service Area, you must take all reasonable steps to contact your PCP for direction and you must receive care from a Participating Provider, unless otherwise authorized by your PCP or the Healthplan.

**Urgent Care Outside the Service Area.** In the event you need Urgent Care while outside the Service Area, you should, whenever possible, contact the CIGNA HealthCare 24 Hour Health Information Line<sup>SM</sup> or your PCP for direction and authorization prior to receiving services.

Urgent Care is defined as medical, surgical, hospital and related health care services and testing which are not Emergency Services, but which are typically provided in a setting such as a physician's or provider's office or urgent care center, as a result of an acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, illness or injury is of such a nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition or his or her health. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or are scheduled to receive services. Such non-Urgent Care includes but

is not limited to: dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that you should not travel due to any medical condition.

**Continuing or Follow-up Treatment.** Continuing, follow-up, or post-stabilization treatment, whether in or out of the Service Area, is not covered unless it is provided or arranged for by your PCP or upon Prior Authorization of the Healthplan Medical Director. Requests made by your treating Physician for post-stabilization treatment will be approved or denied within the time appropriate for your condition and circumstances, but in no situation will the approval or denial be made later than one hour after the request for post-stabilization care has been received by the Healthplan Medical Director.

**Notification, Proof of a Claim, and Payment.** Inpatient hospitalization for any Emergency Services or Urgent Care requires notification to and authorization by the Healthplan Medical Director. Notification of inpatient hospitalization is required as soon as reasonably possible, but no later than within forty-eight (48) hours of admission. This requirement shall not cause denial of an otherwise valid claim if you could not reasonably comply, provided that notification is given to us as soon as reasonably possible. If you receive Emergency Services or Urgent Care from non-Participating Providers, you must submit a claim to us no later than sixty (60) days after the first service is provided. The claim shall contain an itemized statement of treatment, expenses, and diagnosis. This requirement shall not cause denial of an otherwise valid claim if you could not reasonably comply, provided you submit the claim and the itemized statement to us as soon as reasonably possible.

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### Acquired Brain Injuries

Necessary services as a result of and relating to an "acquired brain injury" including: cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community re-integration services.



## IV. Covered Services and Supplies

### Ambulance Service

Ambulance services to the nearest appropriate provider or facility.

### Anesthesia for Dental Procedures

Anesthesia services related to dental procedures in order to safely and effectively perform the dental treatment if you have a serious medical, physical or mental condition.

### Bone Mass Measurement, Hearing Screenings for Newborns and Prostate Cancer Test (PSA)

Bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass is covered for Members who meet the following criteria:

1. post-menopausal women who are not receiving estrogen replacement therapy;
2. a Member with:
  - a. vertebral abnormalities;
  - b. primary hyperparathyroidism
  - c. a history of bone fractures; or
3. a Member who is:
  - a. receiving long-term glucocorticoid therapy; or
  - b. being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

One Screening test for hearing loss for newborn children age birth to thirty (30) days old and necessary diagnostic follow-up care related to the screening test for newborn children age birth through twenty-four (24) months old.

Annual physical examination for the detection of prostate cancer and a prostate-specific antigen test (PSA) for men who are either:

- at least 50 years old and asymptomatic; or
- at least 40 years old with a family history of prostate cancer or another prostate cancer risk factor.

### Breast Reconstruction and Breast Prostheses

Following a mastectomy, the following Services and Supplies are covered:

- surgical services for reconstruction of the breast on which surgery was performed;
- surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance;
- post-operative breast prostheses; and
- mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs.

During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

### Colorectal Cancer Screening

Coverage includes the normal expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer for enrollees 50 years of age or older, and at normal risk for developing colon cancer. These benefits include an annual fecal occult blood test and either a flexible sigmoidoscopy performed every five years or a colonoscopy performed every ten years.

### Contraceptive Coverage

If your Plan provides prescription drug coverage, all FDA-approved contraceptive drugs and devices, including outpatient contraceptive services, shall be covered in accordance with formulary guidelines. Coverage is not provided for abortifacients (“morning-after pill”) or any other drug or device that terminates pregnancy.

Oral contraceptives shall be covered under the prescription drug rider, and standard formulary Copayments will apply. Injectable contraceptives and contraceptive devices that require insertion or implantation by your Physician, shall be covered under the “Covered Services and Supplies” section of this Agreement, and standard medical Copayments shall apply.

### Craniofacial Abnormalities Services

Reconstructive surgery of craniofacial abnormalities for children under eighteen (18) years of age. The



## IV. Covered Services and Supplies

purpose of the surgery is to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused congenital defects, developmental deformities, trauma, tumors, infections or disease.

### Diabetic Services and Supplies

Diabetic services and treatment consisting of diabetes equipment, supplies and self-management training programs as prescribed and rendered by a Participating Provider for insulin dependent or non-insulin dependent diabetes.

Diabetic equipment consisting of blood glucose monitors, including monitors designed to be used by blind individuals; insulin infusion devices; podiatric appliances for the prevention of complications associated with diabetes.

Diabetic supplies including blood glucose test strips; visual reading and urine test strips; lancets and lancet devices; insulin and insulin analogs; injection aids; syringes; glucagon emergency kits; and prescriptive and non-prescriptive oral agents for controlling blood sugar levels.

Investigational and experimental drugs will not be covered.

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### Erectile Dysfunction

Medical diagnostic services to determine the cause of erectile dysfunction. Penile implants are covered when you have an established medical condition that clearly causes erectile dysfunction, such as post-operative prostatectomy and diabetes. Psychogenic erectile dysfunction does not warrant coverage for penile implants.

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### Durable Medical Equipment

Purchase or rental of durable medical equipment that is ordered or prescribed by a Participating Physician and provided by a vendor approved by the Healthplan for use outside a Participating Hospital or Other Participating Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear.

All maintenance and repairs that result from a Member's misuse are the Member's responsibility.

Durable medical equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of illness or injury; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, wheel chairs, and dialysis machines. Durable Medical Equipment items that are not covered, include, but are not limited to those that are listed below.

- **Bed-related items:** bed trays, over the bed tables, bed wedge, custom bedroom equipment, non-power mattress, pillows, posturepedic mattresses, low air loss mattresses (powered), alternating pressure mattresses.
- **Bath-related items:** bath lift, non-portable whirlpool, spas, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held shower, paraffin baths, bath mats, spas.
- **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geri chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized - manual hydraulic lifts are covered if patient is two person transfer), vitrectomy chairs, auto tilt chairs and fixtures to real property (ceiling lifts, wheelchair ramps, automobile lifts-customizations).
- **Air quality items:** room humidifiers, vaporizers, air purifiers, electrostatic machines.
- **Blood/injection related items:** blood pressure cuffs, centrifuges, nova pens, needle-less injectors.
- **Pumps:** back packs for portable pumps.
- **Other equipment:** heat lamp, heating pad, cryounits, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, Enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, exercise equipment, diathermy machines.

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## IV. Covered Services and Supplies

### External Prosthetic Appliances

The initial purchase and fitting of external prosthetic devices ordered or prescribed by a Participating Physician which are used as a replacement or substitute for a missing body part and are necessary for the alleviation or correction of illness, injury or congenital defect.

External prosthetic devices shall include:

- Basic limb prosthetics;
- Terminal devices such as a hand or hook;
- Braces and splints;
- Non-foot orthoses – only the following non-foot orthoses are covered:
  - a) Rigid and semi-rigid custom fabricated orthoses,
  - b) Semi-rigid pre-fabricated and flexible orthoses; and
  - c) Rigid pre-fabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthotics – custom foot orthotics are only covered as follows:
  - a) For Members with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease).
  - b) When the foot orthotic is an integral part of a leg brace and it is necessary for the proper functioning of the brace.
  - c) When the foot orthotic is for use as a replacement or substitute for missing parts of the foot (e.g. amputation) and is necessary for the alleviation or correction of illness, injury, or congenital defect.
  - d) For Members with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

The following are specifically excluded:

- External power enhancements or power controls for prosthetic limbs and terminal devices;

- Orthotic shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers; and
- Orthoses primarily used for cosmetic rather than functional reasons.

Coverage for replacement and repair of external prosthetic appliances is provided only when required due to reasonable wear and tear and/or anatomical change. All maintenance and repairs that result from a Member's misuse are the Member's responsibility.

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### Family Planning Services (Contraception and Voluntary Sterilization)

Family planning services including: medical history; physical examination; related laboratory tests; medical supervision in accordance with generally accepted medical practice; other Medical Services; information and counseling on contraception; implanted/injected contraceptives; and, after appropriate counseling, Medical Services connected with surgical therapies (vasectomy or tubal ligation).

### Home Health Services

Home health services when you:

- require skilled care;
- are unable to obtain the required care as an ambulatory outpatient; and
- do not require confinement in a hospital or Other Participating Health Care Facility.

Home health services are provided only if the Healthplan Medical Director has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), home health services will only be provided for you during times when there is a family member or care giver present in the home to meet your non-skilled care needs.

Home health services are those skilled health care services that can be provided during visits by Other Participating Health Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Participating Health Professionals. Necessary consumable medical



## IV. Covered Services and Supplies

supplies and home infusion therapy, administered or used by Other Participating Health Professionals in providing home health services are covered. Home health services do not include services by a person who is a member of your family or your dependent's family or who normally resides in your house or your dependent's house, even if that person is an Other Participating Health Professional.

### Hospice Services

Hospice care services which are provided under an approved hospice care program when provided to a Member who has been diagnosed by a Participating Physician as having a terminal illness with a prognosis of six months or less to live. Hospice care services include inpatient care; outpatient services; professional services of a Physician; services of a psychologist, social worker or family counselor for individual and family counseling; and home health services.

Hospice care services do not include the following:

- services of a person who is a member of your family or your dependent's family or who normally resides in your house or your dependent's house;
- services and supplies for curative or life-prolonging procedures;
- services and supplies for which any other benefits are payable under the Agreement;
- services and supplies that are primarily to aid you or your dependent in daily living;
- services and supplies for respite (custodial) care; and
- nutritional supplements, non-prescription drugs or substances, medical supplies, vitamins or minerals.

Hospice care services are services provided by a Participating Hospital; a participating skilled nursing facility or a similar institution; a participating home health care agency; a participating hospice facility, or any other licensed facility or agency under a Medicare approved hospice care program.

A hospice care program is a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families; a program that provides

palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness; and a program for persons who have a terminal illness and for the families of those persons.

A hospice facility is a participating institution or portion of a facility which primarily provides care for terminally ill patients; is a Medicare approved hospice care facility; meets standards established by the Healthplan; and fulfills all licensing requirements of the state or locality in which it operates.

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### Infertility Services

Services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include approved surgical and medical treatment programs including artificial insemination and related donor services and fees, that have been established to have a reasonable likelihood of resulting in pregnancy.

This benefit includes diagnosis and treatment of both male and female infertility. However, the following are specifically excluded infertility services:

- infertility drugs;
- in vitro fertilization; gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT) and variations of these procedures;
- Storage of sperm for artificial insemination after one year;
- reversal of voluntary sterilization;
- infertility services when the infertility is caused by or related to voluntary sterilization;
- cryopreservation of donor eggs; and
- any experimental or investigational infertility procedures or therapies.

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### Inpatient Services at Other Participating Health Care Facilities

Inpatient services at Other Participating Health Care Facilities including semi-private room and board; skilled and general nursing services; Physician



## IV. Covered Services and Supplies

visits; physiotherapy; speech therapy; occupational therapy; x-rays; and administration of drugs, medications, biologicals and fluids.

### Internal Prosthetic/Medical Appliances

Internal prosthetic/medical appliances that are permanent or temporary internal aids and supports for non-functional body parts, including testicular implants following medically necessary surgical removal of the testicles. Medically necessary repair, maintenance or replacement of a covered appliance is covered.

### Laboratory and Radiology Services

Laboratory services and radiation therapy and other diagnostic and therapeutic radiological procedures.

### Maternity Care Services

Medical, surgical and hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy.

Coverage for a mother and her newly born child shall be available for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother. In the case of a shorter inpatient stay, one follow-up visit will be provided in the mother's home; the provider's office; a health care facility or some other appropriate location.

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### Chemical Dependency Services

**Chemical Dependency** is defined as the psychological or physical dependence on alcohol or controlled substances (including toxic inhalants) that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of chemical dependency.

### Chemical Dependency Services

Chemical dependency services when required for the diagnosis, treatment and rehabilitation of addiction to alcohol and/or controlled substances. These services will be provided under the same guidelines as other illnesses. The Healthplan Medical Director will decide, based on the Medical Necessity of the situation, whether such services will be provided in an inpatient or outpatient setting.

### Excluded Chemical Dependency Services

The following are specifically excluded from chemical dependency services:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless medically necessary and otherwise covered under this agreement;
- Counseling for occupational problems;
- Residential care; and
- Custodial care.

### Serious Mental Illness Services

Serious Mental Illness is defined as the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

- Schizophrenia;
- Paranoid and other psychotic disorder;
- Bipolar disorder (hypomanic, manic depressive and mixed);
- Major depressive disorders;
- Schizoaffective disorders (bipolar or depressive);
- Pervasive developmental disorders;
- Obsessive-compulsive disorder; and
- Depression childhood and adolescence.

Services of Participating Providers and Participating Hospitals for the treatment and evaluation of a Serious Mental Illness. Visits for the sole purpose of managing and adjusting medications used to treat Serious Mental Illness will not be counted toward outpatient limits.



## IV. Covered Services and Supplies

### Nutritional Evaluation

Nutritional evaluation and counseling from a Participating Provider when diet is a part of the medical management of a documented organic disease, including clinically severe obesity.

### Obstetrical and Gynecological Services

Obstetrical and gynecological services that are provided by qualified Participating Providers for pregnancy, well-women gynecological exams, primary and preventive gynecological care and acute gynecological conditions. For these Services and Supplies you have direct access to qualified Participating Providers; you do not need a Referral from your PCP.

Please note that, in some cases, your PCP may belong to a Limited Network, which means the network that your PCP belongs to may limit your selection of Participating Providers from whom you may choose to access for obstetrical and gynecological services. You should make certain that your PCP's network includes the Specialists, particularly the OB/GYN providers and hospitals, that you prefer. You may elect to receive obstetrical and gynecological services from your Primary Care Physician.

### Organ Transplant Services

Human organ and tissue transplant services at designated facilities throughout the United States. This coverage is subject to the following conditions and limitations.

Organ transplant services include the recipient's medical, surgical and hospital services; inpatient immunosuppressive medications; and costs for organ procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or small bowel/liver.

All organ transplant services other than cornea, kidney and autologous bone marrow/stem cell transplants must be received at a qualified or provisional CIGNA Lifesource Organ Transplant Network® facility. If the facility we designate is out of state, and there is a qualified in-state Participating

Facility able to perform the transplant, we will inform you of the benefits and detriments of the in-state versus out-of-state options so you may choose which facility you wish to receive services in. We will require that you travel out-of-state for your services only if we receive your informed consent.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary.

### Organ Transplant Travel Services

Travel expenses incurred by you in connection with a pre-approved organ/tissue transplant are covered subject to the following conditions and limitations. Organ Transplant Travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available to you only if you are the recipient of a pre-approved organ/tissue transplant from a designated CIGNA Lifesource Organ Transplant Network® facility. The term recipient is defined to include a Member receiving authorized transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the Member receiving the transplant will include charges for:

- transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility);
- lodging while at, or traveling to and from the transplant site; and
- food while at, or traveling to and from the transplant site.

In addition to you being covered for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver.

The following are specifically excluded travel expenses:



## IV. Covered Services and Supplies

- travel costs incurred due to travel within 60 miles of your home;
- laundry bills;
- telephone bills;
- alcohol or tobacco products; and
- charges for transportation that exceed coach class rates.

These benefits are only available when the Member is the recipient of an organ transplant. No benefits are available where the Member is a donor.

### Oxygen

Oxygen and the oxygen delivery system. However, coverage of oxygen that is routinely used on an outpatient basis is limited to coverage within the Service Area. Oxygen Services and Supplies are not covered outside of the Service Area, except on an emergency basis.

### Reconstructive Surgery

Reconstructive surgery or therapy to repair or correct a severe facial disfigurement or severe physical deformity (other than abnormalities of the jaw or related to TMJ disorder) provided that:

- the surgery or therapy restores or improves function; or
- reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or
- the surgery or therapy is performed prior to age nineteen (19) and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part including, but not limited to: microtia, amastia, and Poland Syndrome.

Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the Healthplan Medical Director.

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### Rehabilitative Therapy

Rehabilitative therapy that is part of a rehabilitation program, including physical, speech, occupational,

cognitive, cardiac rehabilitation and pulmonary rehabilitation therapy, provided that:

- The therapy is performed in the most medically appropriate setting; and
- The therapy meets or exceeds the treatment goals for the Member, in the opinion of the treating physician. For a person who is physically disabled, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration.

Chiropractic services are not covered under this rehabilitative therapy provision. These services include the management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

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### Temporomandibular Joint Dysfunction

Diagnostic and treatment services, including surgery, panorex x-rays, lateral transcranial x-rays and/or tomogram and arthrogram, for temporomandibular (jaw or craniomandibular) joint disorders when rendered by a Participating Provider or Participating Facility which are a result of:

- An accident;
- Trauma;
- A congenital defect;
- A developmental defect; and
- A pathology

Dental services are not covered in any situation.

### Vision and Hearing Screenings for Dependents

Vision and hearing screenings provided by your PCP, provided you are under the age of 18 years.

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# V. Exclusions and Limitations

## Section V. Exclusions And Limitations

### Exclusions

Any Services and Supplies which are not described as covered in "Section IV. Covered Services and Supplies" or in an attached Rider or are specifically excluded in "Section IV. Covered Services and Supplies" or an attached Rider are not covered under this Agreement.

In addition, the following are specifically excluded Services and Supplies:

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if the Member is legally entitled to such treatment and facilities are reasonably available.
4. Treatment of an illness or injury which is due to war, declared or undeclared.
5. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
6. Assistance in the activities of daily living, including, but not limited to, eating, bathing, dressing or other custodial or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
7. Any Services and Supplies which are experimental, investigational or unproven services.

Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be:

- not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations; or the American Hospital Formulary Service Drug Information) or in

medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;

- the subject of review or approval by an Institutional Review Board for the proposed use;
  - the subject of an ongoing clinical trial that meets the definition of a phase I, II or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight; or
  - not demonstrated, through existing peer-reviewed literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.
8. Cosmetic surgery or cosmetic therapy, except as specified in the "Craniofacial Abnormalities Services" subsection of "Section IV. Covered Services and Supplies." Cosmetic surgery or therapy is defined as surgery or therapy performed to improve appearance or self-esteem.
  9. Orthognathic treatment/surgery, including but not limited to treatment/surgery for mandibular or maxillary prognathism, microprognathism or malocclusion, surgical augmentation for orthodontics, or maxillary constriction. However, medically necessary treatment of TMJ disorder is covered.
  10. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition including TMJ dysfunction. 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. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
  11. Medical and surgical treatment of obesity and morbid obesity.
  12. 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.



## V. Exclusions and Limitations

13. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Section IV. Covered Services and Supplies."
14. Infertility drugs, which are administered or provided by a Participating Provider, in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and the services of an embryologist, unless an Infertility Services Supplemental Rider is purchased by the Group.
15. Storage of sperm for artificial insemination after one year, reversal of voluntary sterilization procedures, infertility services when the infertility is caused by or related to voluntary sterilization, cryopreservation of donor sperm and eggs and any experimental or investigational infertility procedures or therapies.
16. Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
17. Treatment of erectile dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile dysfunction.
18. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement, under "Section II. Enrollment and Effective Date of Coverage."
19. Non-medical ancillary services including, but not limited to, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, work hardening, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
20. Therapy to improve general physical condition including, but not limited to, routine, long term or nonmedically necessary chiropractic care, which are provided to reduce potential risk factors where significant therapeutic improvement is not expected.
21. Consumable medical supplies, other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to, bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Inpatient Hospital Services", "Outpatient Facility Services", "Home Health Services", "Diabetic Services and Supplies" or "Breast Reconstruction and Breast Prostheses" sections of "Section IV. Covered Services and Supplies."
22. Private hospital rooms and/or private duty nursing unless determined to be Medically Necessary by the Healthplan Medical Director.
23. Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
24. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, hearing aids, dentures and wigs.
25. Chiro Care Services, unless a Supplemental Rider is purchased by the Group.
26. Eyeglass lenses and frames and contact lenses (except for the first pair of contacts for treatment of keratoconus or post-cataract surgery), unless a Vision Care Services Supplemental Rider is purchased by the Group.
27. Routine refractions, unless a Vision Care Services Supplemental Rider is purchased by the Group.
28. Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
29. Treatment by acupuncture.
30. All non-injectable prescription drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Section IV. Covered Services and Supplies", unless a Supplemental Prescription Drug Rider is purchased by the Group.
31. Routine foot care, including the paring and removing of corns and calluses or trimming of nails unless Medically Necessary.
32. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
33. Amniocentesis, ultrasound, or any other procedures requested solely for gender determination of a fetus, unless Medically Necessary to determine the existence of a gender-linked genetic disorder.



## V. Exclusions and Limitations

34. Genetic testing and therapy including germ line and somatic unless determined Medically Necessary by the Healthplan Medical Director for the purpose of making treatment decisions.
35. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
36. Blood administration for the purpose of general improvement in physical condition.
37. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
38. Cosmetics, dietary supplements, health and beauty aids and nutritional formulae. However, nutritional formulae is covered when required for:
  - the treatment of inborn errors of metabolism or inherited metabolic disease (including disorders of amino acid and organic acid metabolism); or
  - enteral feeding for which the nutritional formulae (a) under state or federal law can be dispensed only through a physician's prescription and (b) is Medically Necessary as the primary source of nutrition.
39. Expenses incurred for medical treatment by a person age 65 or older, who is covered under this Agreement as a retiree, or his Dependents, when payment is denied by the Medicare plan because treatment was received from a non-Participating Provider.
40. Expenses incurred for medical treatment when payment is denied by the Primary Plan because treatment was received from a non-participating provider.
41. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.

In addition to the provisions of this "Exclusions and Limitations" section, you will be responsible for payments on a fee-for-service basis for Services and Supplies under the conditions described in the "Reimbursement" provision of "Section VI. Other Sources of Payment for Services and Supplies."

### Limitations

**Circumstance Beyond the Healthplan's Control.** To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within our control results in our facilities, personnel, or financial resources being unavailable to provide or arrange for the provisions of a basic or supplemental health service or supplies in accordance with this Agreement, we will make a good faith effort to provide or arrange for the provision of the services or supplies, taking into account the impact of the event.

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# VI. Other Sources of Payment For Services and Supplies

## Section VI. Other Sources of Payment for Services and Supplies

### Subrogation

If you are injured or rendered ill under circumstances which create a liability for a third party to pay claims or damages to you, we are subrogated to all rights, claims, or interests which you may have against such third party.

To the extent permitted by law, we may recover from the third party the cost of the care which we have provided for you; and

We have the right to recover from the third party to the extent of payments that we have paid for Services and Supplies and not rendered services. If permitted by applicable state or federal law, we may require you, your guardian, personal representative, estate, Dependents, or survivors, as appropriate, to assign your claim or cause of action against the third party to us and to execute and deliver such instruments to secure our right to that claim.

### Reimbursement

If you receive any payment from any third party, including, but not limited to, any worker's compensation fund or carrier, Medicare, a tortfeasor, or any other insurance carrier, for Services and Supplies either rendered or paid by us, we have the right to receive reimbursement from you to the extent that you have received payment as follows:

We have the right to receive reimbursement from you to the extent of the prevailing rates for your care and treatment which we have directly rendered or arranged to be rendered for you; and

We have the right to receive reimbursement from you to the extent that we have paid for Services and Supplies and not rendered services.

If you are not reimbursed from any third party because you knowingly chose not to apply for, or to reject, or to waive coverage, then you will be responsible for payment of all expenses for services rendered on account of such injury or illness. In addition, you will be obligated to fully cooperate with us in any attempts to recover such expenses from your employer if your employer failed to take the steps required by law or regulation to obtain such coverage.

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### Coordination of Benefits

This section applies if you are covered under another plan besides this health plan and determines how the benefits under the plans will be coordinated. If you are covered by more than one health benefit plan, you should file all claims with each plan.

#### A. Definitions

For the purposes of this section, the following terms have the meanings set forth below them:

##### Plan

Any of the following that provides benefits or services for medical care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured, which neither can be purchased by the general public nor is individually underwritten, including closed panel coverage;
- Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies;
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each type of coverage you have in these three (3) categories shall be treated as a separate Plan. Also, if a Plan has two parts and only one part has coordination of benefit rules, each of the parts shall be treated as a separate Plan.

##### Closed Panel Plan

A Plan that provides health benefits primarily in the form of services through a panel of employed or contracted providers and that limits



## VI. Other Sources of Payment For Services and Supplies

or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

### Primary Plan

The Plan that determines and provides or pays its benefits without taking into consideration the existence of any other Plan.

### Secondary Plan

A Plan that determines and may reduce its benefits after taking into consideration the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover the Reasonable Cash Value of any services it provided to you from the Primary Plan.

### Allowable Expense

A necessary, customary, and reasonable health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you; but not including dental, vision or hearing care coverage. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not an Allowable Expense include, but are not limited to the following:

1. An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
2. If you are confined to a private hospital room and no Plan provides coverage for more than the semi-private room, the difference in cost between the private and semi-private rooms is not an Allowable Expense.
3. If you are covered by two or more Plans that provide services or supplies on the basis of usual and customary fees, any amount in excess of the highest usual and customary fee is not an Allowable Expense.
4. If you are covered by one Plan that provides services or supplies on the basis of usual and customary fees and one Plan that provides services and supplies on the basis of

negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.

5. If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Examples of Plan provisions are second surgical opinions and pre-certification of admissions or services.

### Claim Determination Period

A calendar year, but it does not include any part of a year during which you are not covered under this Agreement or any date before this section or any similar provision takes effect.

### Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

### B. Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

1. The Plan that covers you as a Subscriber or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
2. If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as a Subscriber or employee;
3. If you are the Dependent of divorced or separated parents, benefits for the



## VI. Other Sources of Payment For Services and Supplies

Dependent shall be determined in the following order:

- a. first, if a court decree states that one parent is responsible for the child's health care expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - b. Then, the Plan of the parent with custody of the child;
  - c. Then, the Plan of the spouse of the parent with custody of the child;
  - d. Then, the Plan of the parent not having custody of the child, and
  - e. Finally, the Plan of the spouse of the parent not having custody of the child.
4. The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as a laid-off or retired employee (or as that employee's Dependent) shall be the Secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
5. The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
6. If one of the Plans that covers you is issued out of the state whose laws govern this Agreement and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

### C. Effect on the Benefits of this Agreement

If we are the Secondary Plan, we may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than one hundred (100%) percent of the total of all Allowable Expenses.

The difference between the benefit payments that we would have paid had we been the Primary Plan and the benefit payments that we actually paid as the Secondary Plan shall be recorded as a benefit reserve for you. We will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

As to each claim that is submitted, we shall determine the following:

1. Our obligation to provide Services and Supplies under this Agreement;
2. Whether a benefit reserve has been recorded for you; and
3. Whether there are any unpaid Allowable Expenses during the Claim Determination Period.

If there is a benefit reserve, we shall use the benefit reserve recorded for you to pay up to one hundred (100%) percent of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve shall return to zero (0) and a new benefit reserve shall be calculated for each new Claim Determination Period.

### D. Recovery of Excess Benefits

If we provide Services and Supplies that should have been paid by the Primary Plan or if we provide services in excess of those for which we are obligated to provide under this Agreement, we shall have the right to recover the actual



## VI. Other Sources of Payment For Services and Supplies

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payment made or the Reasonable Cash Value of any services.

We shall have the sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments were made; any insurance company; health care Plan or other organization. If we request, you shall execute and deliver to us such instruments and documents as we determine are necessary to secure its rights.

### **E. Right to Receive and Release Information**

We, without consent of or notice to you, may obtain information from and release information to any Plan with respect to you in order to coordinate your benefits pursuant to this section. You shall provide us with any information we request in order to coordinate your benefits pursuant to this section.

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## VII. Termination of Your Coverage

### Section VII. Termination of Your Coverage

We may terminate your coverage for any of the reasons stated below.

#### Termination For Cause

Upon written notice to the Group and you, we may terminate your coverage or your Membership Unit's coverage for cause if any of the following events occur:

1. You omit, misrepresent, or provide materially false information in the Enrollment Application; in which case, we may render coverage of a Membership Unit to be null and void from the effective date of coverage. We will give fifteen (15) days written notice prior to terminating coverage;
2. You permit a non-Member to use your CIGNA HealthCare ID card or to falsely obtain Services and Supplies. We will give fifteen (15) days written notice prior to terminating coverage;
3. You obtain or attempt to obtain Services and Supplies by means of false, misleading or fraudulent information, acts or omissions. We will give fifteen (15) days written notice prior to terminating coverage;
4. You fail to pay any Copayment, or any other amount due as a result of receiving Services and Supplies. We will give thirty (30) days written notice prior to terminating coverage;
5. You fail to establish a satisfactory Physician/patient relationship with any Participating Physician after we assist you in establishing such a relationship. We will give thirty (30) days written notice prior to terminating coverage;
6. Your behavior, in our sole opinion, is disruptive, unruly, abusive or uncooperative to such an extent that we are seriously impaired in our ability to provide services to you or to any other Member. We may terminate coverage immediately;
7. You threaten the life or wellbeing of any Healthplan employee, Participating

Provider, or another Member. We may terminate coverage immediately; or

8. You no longer live, reside or work in the Service Area. We may terminate coverage immediately subject to any applicable continuation of coverage provisions.

In no event, however, will we terminate your coverage due to health status or utilization of Services and Supplies.

#### Termination By Reason of Ineligibility

When you fail to meet the eligibility criteria in "Section II. Enrollment and Effective Date of Coverage" as either a Subscriber or Dependent, your coverage under this Agreement shall cease. Coverage of all Members within a Membership Unit shall cease when the Subscriber fails to meet the eligibility criteria. The Group shall notify us of all Members who fail to meet the eligibility criteria.

Unless otherwise provided by law, if you fail to meet the eligibility criteria your coverage shall cease at midnight of the day that the loss of eligibility occurs, and we shall have no further obligation to provide Services and Supplies.

#### Termination By Termination of This Agreement

This Agreement may be terminated for any of the following reasons:

1. Termination for Non-Payment of Fees. We may terminate this Agreement for the Group's non-payment of any Prepayment Fees owed to us if the fees are not paid to us by the end of the Grace Period.
2. Termination on Notice. The Group, without cause, may terminate this Agreement upon sixty (60) days prior written notice to us. We, without cause, may terminate this Agreement upon either: (i) ninety (90) days prior written notice to the Group of our decision to discontinue offering this particular type of coverage; or (ii) one hundred eighty (180) days prior written notice to the Group of our decision to discontinue offering all coverage in the applicable market. If coverage is terminated in accordance with (i) above, the Group may purchase a type of coverage currently being offered in that market.



## VII. Termination of Your Coverage

3. Termination for Material Change by the Healthplan. The Group may terminate this Agreement upon thirty (30) days prior written notice to us in the case of us making a material change to any provisions we are required to disclose to the Group or its Members.
4. Termination for Fraud or Misrepresentation. We may terminate this Agreement upon thirty (30) days prior written notice to the Group if, at any time, we determine that the Group has performed an act or practice that constitutes fraud or has intentionally misrepresented a material fact.
5. Termination for Violation of Contribution or Participation Rules. We may terminate this Agreement upon thirty (30) days prior written notice to the Group if, after the initial twelve (12) month or other specified time period, it is determined that the Group is not in compliance with the participation and/or contribution requirements as established by us.
6. Termination Due to Association Membership Ceasing. If this Agreement covers an association, we may terminate this Agreement upon thirty (30) days prior notice to the Group in accordance with applicable state or federal law as to a member of a bona fide association if the member is no longer a member of the bona fide association.
7. Termination in Accordance with State and/or Federal law. We may terminate this Agreement upon prior notice to the Group in accordance with any applicable state and/or federal law.
8. Termination for No Eligible Membership. We may terminate this Agreement upon thirty (30) days prior written notice to the Group if no Members of the Group reside, live or work in the Service Area.

Termination Effective Date. Coverage under this Agreement shall terminate at midnight of the date of termination provided in the written notice, except in the case of termination for non-payment of fees, in which case this Agreement shall terminate immediately upon our notice to the Group.

Notice of Termination to Members. If this Agreement is terminated for any reason in this section, the Group shall notify you of the termination effective date and any applicable rights you may have.

Responsibility for Payment. The Group shall be responsible for the payment of all Prepayment Fees due through the date on which coverage ceases. You shall be financially responsible for all services rendered after that date. The Group shall be responsible for providing appropriate notice of cancellation to all Members in accordance with applicable state law. If the Group fails to give written notice to you prior to such date, the Group shall also be financially responsible for, and shall submit to us, all Prepayment Fees due until such date as the Group gives proper notice.

### **Certification of Creditable Coverage Upon Termination**

We will issue you a Certification of Creditable Group Health Plan Creditable Coverage as required by law and based on information provided to us by the Group at the following times:

1. When your coverage is terminated for cause or by reason of ineligibility or you otherwise become covered under "Section VIII. Continuation of Coverage";
2. When your continuation coverage, if you elected to receive it, is exhausted; and
3. When you make a request within twenty-four (24) months after the date coverage expires under either of the above two situations.

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## VIII. Continuation of Coverage

### Section VIII. Continuation of Coverage

#### Continuation of Group Coverage under COBRA

Under the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), an employer must give its employees and dependents the right to continue their group health care benefits. A person who would otherwise lose coverage as a result of a qualifying event is generally entitled to continue the same benefits that were in effect the day before the date of the qualifying event. Coverage may be continued under COBRA only if the required premiums are paid when due and will be subject to future plan changes.

A **qualifying event** is any of the following:

- termination of the Subscriber's employment (other than for gross misconduct) or reduction of hours worked so as to render the Subscriber ineligible for coverage;
- death of the Subscriber;
- divorce or legal separation of the Subscriber from his or her spouse;
- loss of coverage due to the Subscriber becoming entitled to Medicare;
- a Dependent child ceasing to qualify as an eligible Dependent under the plan; or
- if the plan provides coverage for retired Subscribers and eligible Dependents, a qualifying event will also mean a substantial loss of that coverage due to the employer filing for Chapter 11 Bankruptcy. (The substantial loss can occur within one year before or after the filing for Chapter 11 Bankruptcy.)

When there is a divorce or legal separation or a child ceases to qualify as an eligible Dependent, the Subscriber or eligible Dependent is responsible for notifying the employer within 60 days after the date of such qualifying. If the employer is not so notified, the person will not be given the opportunity to continue coverage.

After notification of his or her COBRA rights, the Subscriber or eligible Dependent has a limited amount of time to elect continuation. Continued health care is not automatic.

Continuation of COBRA benefits must be elected within 60 days of the later of the following:

- the date the Subscriber or eligible Dependent loses coverage as a result of the qualifying event; or
- the date the Subscriber or eligible Dependent is notified by the employer of the right to continued coverage.

Notice of the right to continue coverage to your spouse will be deemed notice to any Dependent child residing with your spouse.

The Subscriber or eligible Dependent may be required to pay a premium to continue coverage. If the Subscriber or eligible Dependent elects to continue coverage, the Subscriber or eligible Dependent will have 45 days from the date of election to pay the initial premium due. All subsequent premiums will be due on a monthly basis. There is a 30 day grace period to pay premiums. If the premium is not paid before the expiration of the grace period, COBRA continuation benefits will end.

If elected, the maximum period of continued coverage for a qualifying event involving termination of employment or reduced working hours is 18 months from the date of the qualifying event. However, if a second qualifying event occurs (such as a divorce or death of the Subscriber) within this 18 month period, the period of coverage for any affected Dependent may be extended to up to 36 months from the date of the initial qualifying event.

If a qualified beneficiary is totally disabled under the Social Security Act on the date of the qualifying event, or at any time during the first 60 days of continued coverage, the 18 month period may be extended to up to 29 months. If there are non-disabled family members of this qualified beneficiary who have elected COBRA continuation coverage, they are also entitled to this additional 11 months of coverage. In order for this additional 11 months of coverage to be effective, the Subscriber or eligible Dependent must provide the employer with a copy of the Social Security Administration's determination of total disability within 60 days of receiving such notice. The notice must also be provided to the employer within the initial 18 months of COBRA continuation coverage.



## VIII. Continuation of Coverage

If a covered Subscriber has a qualifying event (termination of employment or reduction in hours worked) and he/she had become entitled to Medicare before the date of this qualifying event, then

- the Subscriber may continue the group health coverage for up to 18 months from the date of termination or reduction in hours worked, and
- any other qualified beneficiary (the spouse and/or children) will be entitled to the greater of (i) 36 months from the date the Subscriber first became entitled to Medicare, or (ii) 18 months from the covered Subscriber's termination or reduction in hours.

The maximum period of continued benefits for a qualifying event involving retired Subscribers of employers under Chapter 11 Bankruptcy and their Dependents will be:

- the date of death of the retired Subscriber; or
- for a surviving spouse or eligible Dependent, 36 months after the date of death of the retired employee.

For all other qualifying events, the maximum period is 36 months, except as provided below.

If the employer provides continuation options in addition to COBRA, the Subscriber or eligible Dependent may elect one of them in lieu of COBRA, but the Subscriber or eligible Dependent may not have both. The election of another continuation option is a waiver of COBRA.

However, if the Plan provides for continuation of existing coverage for a certain period of time after any qualifying event, the Subscriber may receive a COBRA election form when the existing coverage actually ends. The Subscriber or eligible Dependent may elect COBRA continuation coverage for the balance of the 18, 29 or 36 month period.

Other events will cause COBRA benefits to end sooner and this will occur on the earliest of any of the following:

- the date the employer ceases to provide any group health plan to any employee;
- the date the Subscriber or eligible Dependent fails to timely pay any required premium payment;

- the first day after the date of election on which the qualified beneficiary first becomes covered under any other group health plan which does not contain any exclusions or limitations with respect to any pre-existing condition for such person; or the date such exclusion or limitation no longer applies to the Subscriber or Dependent;
- the first day after the date of election on which the qualified beneficiary first becomes entitled to Medicare (except for a Chapter 11 Bankruptcy qualifying event); or
- with respect to a qualified beneficiary whose coverage is being extended for the additional 11 months as described above, coverage will terminate on the first day of the month that is more than 30 days after the date in which the disabled individual is no longer disabled for Social Security purposes.

**IMPORTANT NOTICE - COBRA BENEFITS WILL ONLY BE ADMINISTERED ACCORDING TO THE TERMS OF THE CONTRACT. THE HEALTHPLAN WILL NOT BE OBLIGATED TO ADMINISTER, OR FURNISH, ANY COBRA BENEFITS AFTER THE CONTRACT HAS TERMINATED.**

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### Continuation of Coverage for Certain Dependents Under Texas Law

A Dependent of a Subscriber who continues to live, reside or work in the Service Area, and who has an Event Creating Eligibility, is eligible to continue coverage for himself for a maximum of thirty-six (36) months.

An Event Creating Eligibility for a Dependent to continue coverage under this provision is:

- (a) the severance of the family relationship with Subscriber by way of divorce or attainment of the limiting age;
- (b) the retirement the Subscriber; or
- (c) the death of the Subscriber.

It is the Subscriber's responsibility to give written notification to the Group of any events as described in (a) or (b) within fifteen (15) days of the event.



## VIII. Continuation of Coverage

The Dependent may also notify the Group of these events described in (a), (b) or (c).

To obtain continuation coverage under this provision, the Dependent:

- (a) must have been continuously covered as a Member of the Group for period of at least one year or must be an infant child under one year of age; and
- (b) must give written notice to the Group of the desire to continue coverage, complete any necessary enrollment forms and pay the Group the premium within sixty (60) days from the Event /Creating Eligibility.

The Group is required to notify the Dependent in writing of the option to continue coverage and the duties of continuing coverage immediately after receiving notification of the Event Creating Eligibility.

During the sixty (60) day election period as described in (b) above, coverage under this Agreement will be continued, provided premiums are paid by the Group. At no time will the administrative fee for this coverage exceed five dollars (\$5.00) per month. This fee may be charged in excess of the premium.

Continuation of coverage under this provision will end on the earliest of the following dates:

- (a) the date thirty-six (36) months after the date of the Event Creating Eligibility;
- (b) the date ending the period for which the Dependent makes his last required contribution;
- (c) the date the Dependent becomes or is eligible for Medicare;
- (d) the date the Dependent becomes eligible for similar benefits under any arrangement of coverage; or
- (e) the date, within one year of the date creating eligibility, that the Group replaces this Agreement. In this case the Dependent may receive benefits under the replacement agreement.

Dependents that no longer reside within the Service Area, but continue to reside in the State of Texas and have properly elected continuation of coverage

under this provision, are only entitled to out-of-area emergency benefits while residing outside of the Service Area.

### Continuation of Coverage

Any Member who has completed a continuation of coverage period provided under COBRA or any Dependent who has completed a continuation of coverage period provided to Dependents in accordance with Texas state law may elect to continue coverage for an additional six (6) months, as follows.

A Subscriber and Dependent who continue to live, reside or work in the Service Area, are eligible to continue coverage for six (6) months if they have lost coverage under this Agreement for any reason, including discontinuance of this Agreement except as noted below. To obtain continuation coverage under this provision, the Subscriber or Dependent:

- (a) must have been continuously covered under this Agreement, or similar benefits under any other group policy that was replaced by this Agreement, during the period of three (3) consecutive months immediately prior to termination; and
- (b) must file a written election of continuation coverage with the Group and pay the Group the premium within thirty-one (31) days of the later of; (i) the date the Group coverage would have been otherwise terminated; or (ii) the date the Group gave Subscriber and/or Dependent notice of the right to continuation of coverage.

The Group is required to notify the Subscriber and/or Dependents, in writing, of the duties as described in (b) no later than the date on which coverage would otherwise terminate.

Continuation Coverage shall not be available if termination of coverage occurred because:

- (1) after reasonable notice, the Subscriber failed to make any required contribution toward monthly payment;
- (2) the Subscriber or Dependent is or could be covered by similar group coverage which replaced coverage under this Agreement within thirty-one (31) days after termination of coverage under this Agreement;



## VIII. Continuation of Coverage

- (3) the Subscriber or Dependent is or could be covered by Medicare;
- (4) the Subscriber or Dependent is or could be covered by any other insured or non-insured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination; or
- (5) the Subscriber or Dependent is eligible for COBRA continuation of coverage.

Continuation Coverage will end on the earliest of the following dates:

- (1) the date six (6) months after the date the Subscriber's or Dependent's coverage under this Agreement would have otherwise terminated;
- (2) the date ending the period for which the Subscriber or Dependent last makes his required contribution;
- (3) the date the Subscriber or Dependent becomes or is eligible for similar benefits under any arrangement for coverage on a group basis;
- (4) the date the Subscriber or Dependent becomes or is eligible for Medicare;
- (5) the date the Subscriber or Dependent legally resides outside of the Service Area;
- (6) the date on which this Agreement with the Group is terminated.

At the end of the six-month Continuation Coverage term, the Subscriber or Dependent may be eligible for coverage through the Texas Health Insurance Risk Pool by calling Member Services at the number on your ID Card or by calling the Texas Risk Pool directly at 888-398-3927.

### Availability of Coverage Through the Texas Health Insurance Risk Pool

A Member, who continues to reside in the Service Area, but has lost eligibility for any reason including the expiration of the applicable coverage period under Continuation Coverage, COBRA, etc., may apply within thirty-one (31) days of the loss of eligibility through the Texas Health Insurance Risk Pool. The Member may apply to the Texas Health

Insurance Risk Pool for coverage by calling Member Services at the number on your ID card or by calling the Texas Risk Pool directly at 888-398-3927.

### Continuation of Coverage Under FMLA

If the Group is subject to the requirements of FMLA (the federal law known as the Family and Medical Leave Act of 1993, as amended), the Subscriber shall have coverage under this Agreement during a leave of absence if the Subscriber is an eligible employee under the terms of FMLA and the leave of absence qualifies as a leave of absence under FMLA.

In such a case, the Subscriber shall pay to the Group the portion of the Prepayment Fee, if any, that the Subscriber would have paid had the Subscriber not taken leave and the Group shall pay the Healthplan the Prepayment Fee for the Subscriber as if the Subscriber had not taken leave.

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## Section IX. Miscellaneous

### Additional Programs

We may, from time to time, offer or arrange for various entities to offer discounts, benefits or other consideration to our Members for the purpose of promoting the general health and well being of our Members. Contact us for details regarding any such arrangements.

### Administrative Policies Relating to this Agreement

We may adopt reasonable policies, procedures, rules and interpretations that promote orderly administration of this Agreement.

### Assignability

The benefits under this Agreement are not assignable unless agreed to by the Healthplan. The Healthplan may, at its option, make payment to the Subscriber for any cost of any covered Services and Supplies received by the Subscriber or Subscriber's covered Dependents from a non-participating provider. The Subscriber is responsible for reimbursing the non-participating provider.

### Clerical Error

No clerical error on the part of the Healthplan shall operate to defeat any of the rights, privileges or benefits of any Member.

### Entire Agreement

This Agreement constitutes the entire Agreement between the Healthplan, the Group, and Members and supersedes any previous agreement. Only an officer of the Healthplan has authority to waive any conditions or restrictions of this Agreement, extend the time for making payment, or bind the Healthplan by making any promise or representation, or by giving or receiving any information. No change in the Agreement shall be valid unless stated in a Rider or an amendment attached hereto signed by an officer of the Healthplan. In the event of any direct conflict between information contained in the Group Service Agreement and other collaterals, the terms of the Group Service Agreement shall govern.

### No Implied Waiver

Failure by the Healthplan, the Group, or a Member to avail themselves of any right conferred by this Agreement shall not be construed as a waiver of that right in the future.

### Notice

The Healthplan, the Group, and the Member shall provide all notices under this Agreement in writing, which shall be hand-delivered or mailed, postage pre-paid, through United States Postal Service to the addresses set forth on the Cover Sheet.

### Records

The Healthplan maintains records regarding Members, but the Healthplan shall not be liable for any obligation dependent upon information from the Group prior to receipt by the Healthplan in a form satisfactory to the Healthplan. Incorrect information furnished by the Group may be corrected, if the Healthplan shall not have acted to its prejudice by relying on it. All records of the Group and the Healthplan that have a bearing on coverage of a Member shall be open for review by the Healthplan, the Group or the Member at any reasonable time.

### Severability

If any term, provision, covenant or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of this Agreement shall remain in full force and effect and shall in no way be affected, impaired, or invalidated.

### Successors and Assigns

This Agreement shall be binding upon and shall inure to the benefit of the successors and assigns of the Group and the Healthplan, but shall not be assignable by any Member.

### Service Marks

The CIGNA HealthCare 24 Hour Health Information Line<sup>SM</sup> and CIGNA Lifesource Organ Transplant Network<sup>®</sup> are registered service marks of CIGNA Corporation.



## Supplemental Rider

### Chiropractic Care Services Coverage

This Supplemental Rider is a part of the CIGNA HealthCare of Texas, Inc. Group Service Agreement (“the Agreement”) and is subject to all the terms, conditions and limitations contained therein. The following supplemental Chiropractic Care Services benefit is added to the Agreement.

#### Chiropractic Care Services

Diagnostic and treatment services utilized in an office setting by participating chiropractic Physicians. Chiropractic treatment includes the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function. For these services, you need a referral from your PCP.

The following are specifically excluded from chiropractic care services:

- Services of a chiropractor which are not within his scope of practice, as defined by state law;
- Charges for care not provided in an office setting;
- Maintenance or preventive treatment consisting of routine, long term or non-medically necessary care provided to prevent re-occurrences or to maintain the patient’s current status; and
- Vitamin therapy.

Coverage for chiropractic care services is subject to a copayment as follows:

Services	Copayments
<p><b>Chiropractic Care Services</b></p> <p>Services provided on an outpatient basis are limited to a 60 visit maximum per Member per Contract Year.</p>	<p>\$30 Copayment per office visit</p>



## Schedule of Copayments

**THIS SCHEDULE OF COPAYMENTS IS A SUPPLEMENT TO THE GROUP SERVICE AGREEMENT PROVIDED TO YOU AND IS NOT INTENDED AS A COMPLETE SUMMARY OF THE SERVICES AND SUPPLIES COVERED OR EXCLUDED.**

It is recommended that you review your Group Service Agreement for an exact description of the Services and Supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage. Please see the last page of this document for a definition of terms that are noted in this Schedule of Copayments and are not defined in the Group Service Agreement.

Covered Services and Supplies	Copayments
<p><b>Physician Services</b></p> <p><b>Primary Care Physician Office Visit</b>            Preventive Care            Adult Medical Care            Periodic Physical Evaluation for Adults            Well-Child Care            Routine Immunizations and Injections*            Surgery Performed in the Physician’s Office</p> <p><b>Specialty Care Physician Office Visit</b>            Office Visits            Consultant and Referral Physician Services            Surgery Performed in the Physician’s Office</p>	<p>\$30 Copayment per office visit</p> <p>The office visit Copayment will be waived when immunization is the only service provided</p> <p>*No Copayment will be charged for children birth through age 6</p> <p>\$50 Copayment per office visit</p>
<p><b>Inpatient Hospital Services</b></p> <p>Semi Private Room and Board            Physician and Surgeon Charges            Laboratory, Radiology and other Diagnostic and Therapeutic Services            Administered Drugs, Medications, Biologicals and Fluids            Special Care Units            Operating Room, Recovery Room            Anesthesia            Inhalation Therapy            Radiation Therapy and Chemotherapy</p>	<p>\$500 Copayment per admission</p>



Covered Services and Supplies	Copayments
<p><b>Outpatient Facility Services</b>            Operating Room, Recovery Room,            Procedures Room, and Treatment Room including              Physician Services              Laboratory and Radiology Services              Administered Drugs, Medications, Biologicals                and Fluids              Anesthesia              Inhalation Therapy</p>	\$150 Copayment per facility use
<p><b>Emergency and Urgent Care Services</b></p> <p>    <b>Physician's Office</b></p> <p>    <b>Hospital Emergency Room or Outpatient Facility</b></p> <p>    <b>Urgent Care Facility</b></p>	<p>Same as Physician Office Visit Copayment</p> <p>\$150 Copayment per visit</p> <p>The emergency room Copayment will be waived if you are admitted to a participating hospital directly from the emergency room</p> <p>\$75 Copayment per visit</p>
<p><b>Ambulance Services</b></p>	No Charge
<p><b>Anesthesia for Dental Treatment</b></p>	Same as Physician Office Copayment or Outpatient Facility Copayment, as applicable
<p><b>Bone Mass Measurement, Hearing Screening for Newborns and Prostate Cancer Test</b></p>	Same as Physician Office Copayment, Outpatient Facility Copayment or Inpatient Hospital Copayment, as applicable
<p><b>Diabetic Services and Supplies</b></p> <p>    <b>Self Management Courses</b></p> <p>    <b>Equipment</b></p> <p>    <b>Insulin and other Diabetic Pharmaceutical Supplies</b></p>	<p>Same as Physician Office Visit Copayment</p> <p>Same as Durable Medical Equipment Copayment per item</p> <p>Same as Prescription Drug Copayment</p>



# Schedule of Copayments

Covered Services and Supplies	Copayments
<b>Durable Medical Equipment</b> \$3,500 maximum per Member per Contract Year.	No Charge
<b>External Prosthetic Appliances</b> \$200 deductible per Member per Contract Year. \$1,000 maximum per Member per Contract Year.	No Charge after the deductible
<b>Family Planning Services</b>  <b>Office Visits (Tests, Counseling)</b>  <b>Surgical Sterilization Procedures</b>	Same as Physician Office Visit Copayment  Same as Inpatient Hospital, Outpatient Facility or Physician Office Visit Copayment, depending on facility used
<b>Home Health Services</b>	No Charge
<b>Hospice Services</b>  <b>Inpatient Services</b>  <b>Outpatient Services</b>	Same as Inpatient Hospital Copayment  No Charge
<b>Infertility Services</b>  <b>Physician Office Visit</b>  <b>Surgical Treatment</b>	Same as Physician Office Visit Copayment  50% Copayment per procedure
<b>Inpatient Services at Other Participating Health Care Facilities</b>  <b>Rehabilitation Hospital</b>  <b>Skilled Nursing Facility and Sub-Acute Facilities</b>  60 day maximum per Member per Contract Year	Same as Inpatient Hospital Copayment  Same as Inpatient Hospital Copayment



Covered Services and Supplies	Copayments
<b>Laboratory and Radiology Services</b>	
<b>MRIs, MRAs, CAT scans and PET scans</b>	\$75 Copayment
<b>Other Laboratory and Radiology Services</b>	No Charge
<b>Maternity Care Services</b>	
<b>Initial Office Visit to Confirm Pregnancy</b>	Same as Physician Office Visit Copayment
<b>All other Office Visits</b>	No Charge
<b>Delivery</b>	Same as Inpatient Hospital Copayment
<b>Mental Health and Chemical Dependency Services</b>	
<b>Inpatient Mental Health Services</b> 8 day maximum per Member per Contract Year	\$100 Copayment per day
<b>Outpatient Individual Mental Health Services</b> 20 visit maximum per Member per Contract Year	\$40 Copayment per visit
<b>Outpatient Mental Health Group Therapy</b> 40 visit maximum per Member per Contract Year	\$20 Copayment per visit
<b>Inpatient Chemical Dependency Services</b>	Same as Inpatient Hospital Copayment
<b>Outpatient Individual Chemical Dependency Services</b>	Same as Physician Office Visit Copayment
<b>Outpatient Group Chemical Dependency Services</b> Chemical Dependency Services are limited to a maximum of three (3) separate series of treatments per lifetime. One treatment series is when the member is discharged on medical advice from a treatment facility or the member fails to comply with a planned treatment program for a period of thirty (30) consecutive days.	Same as Physician Office Visit Copayment



# Schedule of Copayments

Covered Services and Supplies	Copayments
<b>Serious Mental Illness</b>	
<b>Inpatient Serious Mental Illness Services</b> 45 day maximum per member per contract year	Same as Inpatient Hospital Copayment
<b>Outpatient Serious Mental Illness Services</b> 60 visit maximum per member per contract year	Same as Physician Office Visit Copayment
<b>Organ Transplant Travel Services Maximum</b> \$10,000 maximum benefit	
<b>Rehabilitative Therapy</b>	\$30 Copayment per office visit
<b>Temporomandibular Joint Dysfunction Services</b>	Same as Physicians Office Copayment or Outpatient Facility Copayment, as applicable

Total Copayment Maximum *	
<b>Individual Member Total Copayment Maximum</b>	\$2,500 per Contract Year
<b>Membership Unit Total Copayment Maximum</b>	\$5,000 per Contract Year

\*Only Copayments identified in this Schedule of Copayments which have been paid by a Member for Inpatient Hospital Services, Outpatient Facility Services (including Hospital Emergency Room or Outpatient Facility Copayments), Inpatient Services at Other Participating Health Care Facilities, Inpatient Mental Health Services, Inpatient Substance Abuse Rehabilitation and Inpatient Detoxification Services apply to these maximums. It is the Member's responsibility to maintain a record of Copayments, which have been paid, and to inform the Healthplan when the amount reaches the Total Copayment Maximum.

### Basic Health Services Copayment Maximums:

In no event shall any Copayment charged for any single Basic Health Service exceed the lesser of: (1) the Copayment amount for the Basic Health Service shown in the Schedule of Copayments; or (2) fifty percent (50%) of the total cost of providing the service to a Member. The Annual Copayment Maximum for Basic Health Services cannot exceed two hundred percent (200%) of the total annual premium cost which is required to be paid by or on behalf of the Member.

## DEFINITIONS:

**Maximum Allowance** The total benefit paid by CIGNA HealthCare for a Covered Service or Supply, wherein the Member pays the remaining balance.



Contracted Rate	Discounted fee for service agreed upon between CIGNA HealthCare and the Provider.
Basic Health Services	<ul style="list-style-type: none"><li>(1) Diabetes Services &amp; Supplies;</li><li>(2) Laboratory and Radiology and other Diagnostic and Therapeutic Services;</li><li>(3) Home Health Services;</li><li>(4) Inpatient and Outpatient Services, including Rehabilitative Therapy;</li><li>(5) Services for treatment of breast cancer and related procedures;</li><li>(6) Twenty (20) Outpatient Mental Health visits per calendar year;</li><li>(7) Maternity Care Services;</li><li>(8) Physician Services;</li><li>(9) Preventive health benefits for family planning services, infertility medical services for artificial insemination and medical treatment to diagnose and treat the medical cause of the infertility, well child care from birth, periodic health evaluations for adults and annual well woman examinations, diagnostic examinations for detection of prostate cancer, annual eye and ear examinations for children through age 17, pediatric and adult immunizations; and</li><li>(10) Transplants.</li></ul>



## Supplemental Rider

This Supplemental Rider is a part of the CIGNA HealthCare of Texas, Inc. Group Service Agreement ("the Agreement") and subject to all of the terms, conditions and limitations contained therein. In consideration for an additional monthly fee incorporated into the Prepayment Fee, the following supplemental prescription drug benefit is added to the Agreement.

## Prescription Drugs

### I. Definitions

**Formulary** means a listing of approved Prescription Drugs, and Related Supplies. The Prescription Drugs and Related Supplies included in the Formulary have been approved in accordance with the parameters established by the P & T Committee. The Formulary is regularly reviewed and updated.

**Participating Pharmacy** means 1) a retail pharmacy with which the Healthplan has contracted to provide prescription services to Members, or 2) a designated mail order pharmacy with which the Healthplan has contracted to provide mail order prescription services to Members.

**Pharmacy & Therapeutics (P&T) Committee.** A committee of CIGNA HealthCare Participating Providers, Pharmacists, Medical Directors and Pharmacy Directors which regularly reviews Prescription Drugs and Related Supplies for safety, efficacy, cost effectiveness and value. The P&T Committee evaluates Prescription Drugs and Related Supplies for addition to or deletion from the Formulary and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies.

**Prescription Drug** means (i) a drug which has been approved by the Food and Drug Administration for safety and efficacy, (ii) certain drugs approved under the Drug Efficacy Study Implementation review or (iii) drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a prescription order.

**Prescription Order** means the lawful authorization for a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of such Physician's

professional practice or each authorized refill thereof.

**Related Supplies** means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under this Prescription Drug benefit and spacers for use with oral inhalers.

### II. Services and Benefits

A Member shall be entitled to purchase from Participating Pharmacies, as designated by Healthplan, those Medically Necessary Prescription Drugs and Related Supplies, ordered by a Physician. Healthplan will also cover Medically Necessary Prescription Drugs and Related Supplies dispensed by a Participating Pharmacy, with a prescription issued to a Member by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When a Member is issued a prescription for a Prescription Drug or Related Supply as part of the rendering of Emergency Services and a Participating Pharmacy cannot reasonably fill such prescription, such prescription will be covered by Healthplan, subject to the provisions of this rider.

### III. Limitations

Each prescription order or refill shall be limited as follows:

- to up to a consecutive thirty (30) day supply at a retail Participating Pharmacy; or
- to up to a consecutive ninety (90) day supply at a mail order Participating Pharmacy; or
- to a dosage and/or dispensing limit as determined by the P&T Committee.

Coverage for certain Prescription Drugs and Related Supplies require your Physician to obtain prior authorization prior to prescribing. If your Physician wishes to request coverage for a Prescription Drug or Related Supply for which prior authorization is required, your Physician may call or complete the appropriate prior authorization form and fax it to CIGNA HealthCare to request prior authorization for coverage of the Prescription Drug or Related Supply. Your Physician should make this request before writing the prescription.

If the request is approved, your Physician will receive confirmation. The authorization will be



processed in our claim system to allow you to have coverage for this Prescription Drug or Related Supply. The length of the authorization will depend on the diagnosis and Prescription Drug or Related Supply. When your Physician advises you that coverage for the Prescription Drug or Related Supply has been approved, you should contact the Participating Pharmacy to fill the prescription(s).

If the request is denied, your Physician and you will be notified that coverage for the Prescription Drug or Related Supply is not authorized.

If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the Agreement, by submitting a written request stating why the Prescription Drug or Related Supply should be covered.

If you have questions about a prior authorization request, you should call Member Services at the toll-free number on the CIGNA HealthCare ID card.

All newly Federal Drug Administration (FDA) approved drugs are designated as non-Formulary Prescription Drugs until the P&T Committee evaluates the Prescription Drug clinically and considers whether it may be placed on the Formulary. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

#### IV. Member Payments

Coverage for Prescription Drugs and Related Supplies is subject to a Copayment, Deductible and Contract Year Maximum, if any. The applicable Copayments, Deductibles and Maximums, if any, are identified in the Prescription Drug Schedule of Copayments. In no event will the Copayment exceed the cost of the Prescription Drug or Related Supply.

When a treatment regimen contains more than one type of Prescription Drug which are packaged together for the convenience of the Member, a Copayment will apply to each Prescription Drug.

#### V. Exclusions

Except as otherwise set forth in this Rider, coverage for Prescription Drugs and Related Supplies is subject to the exclusions and limitations set forth in the "Exclusions and Limitations" Section of the Agreement. In addition, any services or benefits related to Prescription Drugs and Related Supplies, which are not described in this Supplemental Rider, are excluded from coverage under the Agreement. By way of example, but not of limitation, the following are specifically excluded services and benefits:

1. Any drugs available over the counter that do not require a prescription by Federal or State Law, and any drug that is a pharmaceutical alternative to an over the counter drug other than insulin.
2. Any drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee (such as anti-histamines).
3. Any injectable drugs including injectable infertility drugs, other than injectables, included on the Formulary, used to treat diabetes, acute migraine headaches, anaphylactic reactions, vitamin deficiencies and injectables used for anticoagulation. However, upon prior authorization by Healthplan Medical Director, injectable drugs may be covered subject to the required Copayment.
4. Any drugs that are experimental or investigational, within the meaning set forth in the Agreement.
5. Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal.



6. Any prescription and non-prescription supplies (such as, ostomy supplies), devices, and appliances other than Related Supplies.
7. Norplant and other implantable contraceptive products, except as covered in the Agreement.
8. Any fertility drug.
9. Any drugs used for treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido.
10. Any prescription vitamins (other than pre-natal vitamins), dietary supplements and fluoride products.
11. Drugs used for cosmetic purposes, such as, drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products.
12. Any diet pills or appetite suppressants (anorectics).
13. Prescription smoking cessation products.
14. Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
15. Replacement of Prescription Drugs and Related Supplies due to loss or theft.
16. Drugs used to enhance athletic performance.
17. Drugs which are to be taken by or administered to a Member while the Member is a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.
18. Prescriptions more than one year from the original date of issue.



## Prescription Drug Schedule of Copayments

Type of Drug	Copayment	
	Retail Participating Pharmacy Copayment (applies to each Prescription Order or refill.)	Mail Order Pharmacy Copayment (applies to each Prescription Order or refill.)
Formulary Generic*	\$10	\$20
Formulary Name Brand* with no Generic equivalent	\$20	\$40
Formulary Name Brand* with a Generic equivalent and non-formulary	\$50	\$100

\* Designated as per generally-accepted industry sources and adopted by Healthplan



## **CIGNA HealthCare 24-Hour Health Information Line<sup>SM</sup> 1.800.564.8982**

### **The Health Information Nurses**

A specially trained team of registered nurses is on duty around the clock. Your nurse will ask you a few questions about your symptoms and situation, then direct you to the type of care that should make you more comfortable.

- If your condition doesn't require immediate care, your nurse will recommend steps you can take to be more comfortable until you see your doctor.
- If you're away from home, the nurses can help you locate nearby participating doctors, facilities and pharmacies.
- If you need urgent care, your nurse will direct you to the nearest qualified provider or facility and help you with any necessary authorizations.
- If it appears that you need emergency care, your nurse will direct you to call 911 or other emergency services in your area. Your nurse will help you access the appropriate services.
- If you're directed to seek immediate medical attention, we'll provide your primary care physician with the details. This information becomes part of your medical records, updates your health status and alert your doctor to the need for follow-up care.

### **The Health Information Library**

You can listen to tapes on topics ranging from aging and women's health to nutrition and surgery. The tapes are regularly updated to include new treatments and medical data. You can listen to as many tapes as you like, and this booklet includes a handy directory to hundreds of subjects.

### **It's simple to use, easy to understand**

- Just call 1.800.564.8982.
- Follow the simple instructions that quickly guide you to the information you need. If you have a rotary-dial phone, stay on the line for assistance.
- Use this handy directory to enter the code numbers of the programs you'd like to hear.
- There's no limit to the number of programs you can request in a single call.

### **Nurses are always standing by**

To speak with a Health Information Nurse at any time during your call - even if you're in the middle of a Health Information Library tape - our system will quickly and automatically connect you.

### **Call us if you're concerned or just curious**

- Use the 24-Hour Health Information Line for helpful, everyday health information on all sorts of subjects, from sleeplessness to sunburn.
- You'll really appreciate this service if you have young children.
- If it's difficult for your primary care physician to call you back - if you're vacationing or traveling on business, if you're retired and travel often, or if you have kids away at school - the Health Information Line is a valuable first step in learning about and caring for everyday health matters.

Don't wait, don't wonder, or possibly delay necessary treatment or helpful self-care. Call the CIGNA HealthCare 24-Hour Health Information Line<sup>SM</sup> and get the information you need. Quickly and easily.



### Health Information Library

1.800.564.8982

#### Aging

7801 Adult Day Care Centers  
 7802 Adult Protective Services  
 7803 Aging: Physical Changes  
 7804 Alcohol and Aging  
 7805 Alzheimer's Disease  
 7886 Benefits for Veterans  
 7809 Cataract Quiz  
 7810 Colon Polyps  
 7811 Community Living Options  
 7812 Constipation and Aging  
 7813 Delirium: Acute Confusion  
 7814 Dementia  
 7815 Dentures  
 7816 Depression in Older Adults  
 7823 Durable Power of Attorney for Healthcare  
 7824 Elderhostel and Adult Education  
 7825 Exercise for Seniors  
 7826 Extended Care Facilities  
 7827 Family Caregivers  
 7830 Healthy Behaviors for Seniors  
 7837 Hip Fracture  
 7839 Home Healthcare  
 7840 Home Safety Tips  
 7842 Hydration: Getting Enough Water  
 7843 Immunizations for Seniors  
 7845 Impotence in Older Men  
 7849 Lifespan and Aging  
 7850 Living Independently  
 7851 Living Will  
 7852 Loneliness  
 7853 Long-Term Care Insurance  
 7835 Maintaining Independence  
 7854 Medicaid  
 7856 Medicare: Part A & B  
 7808 Medication and Depression in Older Adults  
 7857 Medication Safety  
 7859 Nursing Homes  
 7860 Nutrition for the Later Years  
 7864 Pets for the Elderly: The Benefits  
 7865 Planning for Retirement  
 7866 Preventing Falls  
 7847 Residential Care  
 7871 Self-Esteem in Older Adults  
 7877 Skin Problems in The Elderly  
 7874 Senior Centers  
 7875 Sex in the Later Years

7878 Sleep Problems  
 7880 Social Security and SSI  
 7881 Staying Active After Retirement  
 7882 Stress in the Senior Years  
 7883 Stroke Risks in Older Adults  
 7884 Taking Medication  
 7885 Talking to Your Doctor

#### Alcohol Problems

4134 Alcohol: How Much is too Much?  
 4131 Alcoholism: Causes  
 4132 Alcoholism: Information and Resources  
 4133 Alcoholism: The Disease of Denial  
 4135 Intervention: Getting the Alcoholic into Treatment  
 4136 Recovery: The Twelve Step Approach  
 4137 Symptoms of Alcoholism  
 4138 Teenage Drinking

#### Allergies

4151 Allergic Shock (Anaphylaxis)  
 4150 Allergies: National Support Services  
 4160 Allergy Proof Your Home  
 4152 Allergy Testing  
 4162 Allergy Treatment  
 4161 Drug Allergy  
 4154 Food Allergies  
 4155 Hay Fever  
 4156 Insect Bites and Stings  
 4159 Poison Ivy, Oak, and Sumac  
 4157 Skin Allergies  
 4947 Skin Tests  
 4158 What is an Allergy?

#### Arthritis

4171 Arthritis: Symptoms  
 4179 Arthritis: Treatment  
 4174 Arthritis: Chores Made Easier  
 4176 Arthritis: Rheumatoid  
 4177 Arthritis: What is it?  
 4173 Aspirin and Arthritis  
 4180 Infectious Arthritis  
 4181 Juvenile Rheumatoid Arthritis  
 4175 Osteoarthritis  
 4178 Who's at Risk for Arthritis?

#### Back and Neck

4191 Back Exercises  
 4203 Back Pain  
 4192 Back Pain: Causes  
 4196 Back Pain: Prevention  
 4197 Back Pain: Self-Care  
 4206 Back: Lower Back Injuries  
 4193 Exercises for the Desk Bound  
 4194 Lift it Right  
 4195 Neck Exercises  
 4204 Neck Injuries  
 4199 Neck Pain  
 4200 Neck Pain Treatment  
 4205 Slipped Disc  
 4201 Torticollis  
 4198 Whiplash

#### Blood and Circulatory

4211 Anemia  
 6104 Aneurysms  
 4212 Blood Clots  
 4219 Blood Donation Procedure  
 6146 Blood Pressure: Low  
 4213 Blood Transfusions  
 4220 Hemophilia  
 4214 Peripheral Vascular Disease  
 4215 Phlebitis and Thrombosis  
 4216 Sickle Cell Disease  
 4221 Transfusion with Your Own Blood  
 4217 Varicose Veins  
 4218 Varicose Veins: Treatment

#### Bones, Joints and Muscles

7601 Amputation  
 7602 Anti-Inflammatory Medications  
 4231 Arthroscopic Surgery  
 7603 Artificial Limb  
 7604 Bowlegs and Knock-Knees  
 4232 Bursitis  
 4241 Carpal Tunnel Release  
 4233 Carpal Tunnel Syndrome  
 7605 Cast Care  
 7606 Collateral Ligament Knee Injury  
 7607 Costochondritis  
 7608 Cruciate Ligament Knee Injury  
 7649 Dermatomyositis  
 7609 Dupuytren's Contracture  
 4243 Fibromyalgia (Fibromyositis)  
 7611 Finger Dislocation  
 7614 Fracture Treatment  
 7615 Fracture Types  
 7616 Ganglion  
 4239 Gout  
 4246 Gout: Purine Modified Diet  
 7618 Heel Pain  
 7619 Hip Dislocation: Childhood  
 4234 Hip Replacement  
 4235 Knee Replacement  
 7620 Kyphosis  
 7621 Legg-Calve-Perthes Disease  
 7622 Lumbar Lordosis  
 7623 Lumbar Stenosis  
 4240 Lupus  
 7625 Meniscus Injury to Knee  
 7447 Muscle Cramps and Spasms  
 4245 Muscle Pain  
 7626 New Cast Materials  
 7627 Orthopaedic Appliances  
 7628 Orthopaedics: A Medical Specialty  
 7629 Osgood-Schlatter Disease  
 7630 Osteogenesis Imperfecta  
 7631 Osteomyelitis  
 7551 Overuse Injuries  
 7632 Paget's Disease of Bone  
 7633 Patellofemoral Syndrome or Chondromalacia  
 7634 Pigeon Toe (In-Toeing)  
 7650 Polymyalgia Rheumatica  
 7651 Polymyositis  
 7635 Preventing a Broken Hip  
 7636 Pulled Elbow in Children  
 7637 Rotator Cuff Injury  
 4244 Rotator Cuff Repair  
 7652 Scleroderma  
 7638 Scoliosis  
 7639 Shoulder Dislocation  
 7641 Slipped Capital Femoral Epiphysis  
 7640 Slipped Disc  
 7642 Spinal Fusion  
 7617 Spinal Instrumentation  
 7643 Spondylolysis  
 7561 Sprains and Strains  
 7644 Total Shoulder Replacement  
 7645 Using Crutches Safely



7647 What is Physical Therapy?

### Brain and Nervous System

4259 Bell's Palsy  
 4251 Brain Tumor  
 4252 Epilepsy  
 4260 Lou Gehrig's Disease  
 4253 Meningitis  
 4254 Narcolepsy  
 4255 Paralysis After Injury  
 4256 Parkinson's Disease: Symptoms  
 4257 Pinched Nerves  
 4258 Stroke

### Cancer

6401 Bladder Cancer  
 6402 Bone Cancer  
 6472 Bone Marrow Transplant  
 6473 Brain Tumors in Children  
 6406 Breast Cancer  
 4284 Breast Cancer in Men  
 6410 Can Your Diet Prevent Cancer?  
 6411 Cancer Information Resources  
 6474 Cancer Screening  
 4285 Cancer Treatment Team  
 4288 Cancer Treatment: Side Effects  
 4286 Cancer: Clinical Trials  
 6413 Cervical Cancer  
 6415 Chemotherapy  
 6417 Colon Cancer  
 6420 Diagnosing Cancer  
 6422 Endometrial Cancer  
 6424 Esophageal Cancer  
 6426 Hodgkin's Disease (Hodgkin's Lymphoma)  
 6475 Immunotherapy  
 6427 Importance of Early Detection  
 6476 Kidney Cancer  
 6428 Leukemia: Acute  
 6429 Leukemia: Chronic  
 6430 Liver Cancer  
 6437 Lung Cancer  
 6477 Malignant Melanoma  
 4287 Metastatic Cancer  
 6478 Multiple Myeloma  
 6439 Non-Hodgkin's Lymphomas  
 6479 Nutrition and Cancer  
 6443 Ovarian Cancer  
 6480 Pain Control and Cancer  
 6446 Palliative Surgery  
 6481 Pancreatic Cancer  
 6482 Patient Controlled Analgesia System

6483 Premalignant Skin Lesions

6484 Prostate Cancer  
 6485 Prostate Specific Antigen  
 6450 Protecting Yourself from Cancer  
 6451 Radiation Therapy  
 6452 Risk Factors for Cancer  
 6453 Seven Warning Signs of Cancer  
 6455 Skin Cancer  
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