



CIGNA HealthCare

Valassis Direct Mail

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

This document takes the place of any documents previously
issued to you which described your benefits.



CIGNA HealthCare



Thank you for choosing CIGNA HealthCare.

We are pleased to provide important information about your HMO plan.

Your plan:

- **Does more than provide coverage when you're sick or injured.** We focus on helping you take care of yourself so you can stay your healthiest.
- **Includes preventive care services.** We cover physicals, child immunizations, and women's health services such as no-referral OB/GYN checkups, mammograms and Pap tests. You'll also receive membership discounts on health and wellness programs and services.
- **Covers emergency and urgent care, 24 hours a day, worldwide.**

It's easy to get the information you need.

- **myCIGNA.com** offers a number of self-service features. You can review your benefits plan information; find participating physicians, specialists, pharmacies and hospitals closest to home or work; view the status of your claims; order a new CIGNA HealthCare ID card; or change your PCP.
- **Member Services representatives** are ready to answer your questions and help solve problems. Just call the toll-free number on your CIGNA HealthCare ID card.
- **Your CIGNA HealthCare ID card** lists the toll-free Member Services phone number, your PCP's name and phone number, and payment information.

We want you to be satisfied with your CIGNA HealthCare plan. If you ever have a question about your plan, just call. We're here to help.



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CIGNA HealthCare Overview

The Benefits of Belonging

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

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 can choose his or her own PCP.

Your plan includes:

- **Preventive care** – coverage for regular checkups, tests and childhood immunizations.
- **Women’s health** includes referral-free OB/GYN care with participating CIGNA HealthCare physicians, mammograms and Pap tests. Also includes no-copayment prenatal care after the initial visit to confirm pregnancy.
- **Mental health and substance abuse services coverage.** 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 on your CIGNA HealthCare ID card. You can call 24 hours a day, seven days a week.
- **24-hour emergency coverage**, worldwide.
- **Access to the CIGNA HealthCare 24-Hour Health Information LineSM.** No matter where you are in the U.S. helpful information is as close as the nearest phone. Information, instructions on how to access the 24-Hour Health Information Line and a complete listing of Health Information Library topics are included later in this Overview.
- **CIGNA Healthy Rewards[®]** expands your health care options, giving you access to health and wellness programs often not covered by many traditional benefits plans. At the same time, you save money through discounts on Weight Watchers[®], acupuncture, chiropractic care,

therapeutic massage, laser vision correction, smoking cessation, and more. Check it out at myCIGNA.com, or call 1.800.870.3470. This program is not available in all states.

- **CIGNA Well Aware for Better Health[®]** can help you manage certain chronic conditions.
- **CIGNA Lifesource Transplant Network[®]** gives you access to participating organ and tissue transplant centers nationwide. We offer personalized care, management and a travel expense allowance. Call Member Services to learn more.
- **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 network available.

Hospitalization

If your condition or diagnosis requires hospitalization, CIGNA HealthCare will help facilitate your care arrangements.

If you need hospitalization you have a wide range of choices. Many of your area’s hospitals participate in the CIGNA HealthCare network. But no matter which participating hospital you choose, your admission must be approved in advance by CIGNA HealthCare.

- Your doctor will work with CIGNA HealthCare to arrange for precertification. A health care professional will review your request promptly and notify your doctor of the approved length of stay.
- If we have questions or do not approve your stay, we will discuss the details with your doctor and reach an agreement regarding appropriate, covered hospital services.
- Your precertification covers only the approved length of stay. Hospitalizations beyond the approved length may not be covered or will be covered at a reduced rate.
- If medical complications require a longer stay, outpatient care or other types of continuing care, you will be covered as long as your doctor authorizes it through CIGNA HealthCare.
- If your hospitalization is for a maternity stay, no authorization is required for a 48-hour stay for



vaginal deliveries or a 96-hour stay for Cesarean section. Longer stays must be authorized by CIGNA HealthCare.

Outpatient Care

Some medical procedures are handled best in an outpatient setting. Your costs will be lower and in most cases, you'll be home the same day, returning to your normal lifestyle as soon as possible. Your doctor will help you decide which procedures require hospital care and which can be handled on an outpatient basis.

If your condition requires outpatient care, CIGNA HealthCare will help facilitate your care. Your doctor will arrange for precertification. (If the service is for mental health or substance abuse, and your CIGNA HealthCare benefits include mental health/substance abuse services, ask to speak with a CIGNA Behavioral Health Customer Service Representative.)

If you have questions about outpatient care, precertification or which procedures must be precertified, just call Customer Service at the toll-free number on your CIGNA HealthCare ID card.



If You Have a Question

This Overview 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

We strive to make sure that the answers you need are always close by.

Your CIGNA HealthCare ID Card

Your CIGNA HealthCare 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 benefits and services your plan offers as long as you are eligible.

- Carry it with you at all times.
- Show it whenever you access 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.

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 we offer Language Line Services, which translates more than 150 other languages.
- Our interactive voice response system helps you find what you need faster over the phone. Use the speech recognition feature for information on your benefits, level of coverage, claims status, and more.

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 Provider Directory or more detailed information about a doctor or hospital.
- You want to change your PCP.

myCIGNA.com

This personalized, convenient, and secure web site is your:

Personal health and wellness manager. Combining your plan information with interactive tools, myCIGNA.com helps you identify health risks, learn about conditions, treatments and medications, and take steps to stay healthy. These tools make it easy to learn the facts to help you decide where to get care. Comparing costs and providers can make a difference in the type and quality of services you receive and what you ultimately pay. You can get average price ranges for certain ambulatory surgical procedures and radiology services. You can also find estimated costs in your region for common medical services and conditions.

Information Center. Chart your progress on key health indicators, store your information where you can find it quickly and easily, and explore a range of health and wellness topics.

Benefits Resource. Find participating providers, download and print claim forms whenever you need them, and learn more about your plan and the benefits and programs available to you.

Emergencies

Examples of emergency situations can include:

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

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.

- You may 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 should 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 can 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 LineSM. For more information about emergency care, please see Section IV in the Group Service Agreement.

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

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 LineSM 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.

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

CIGNA HealthCare Healthy Babies[®]

The CIGNA HealthCare Healthy Babies program gives mothers-to-be the information and support they need to make the best choices for mom and baby.

When you enroll in Healthy Babies you'll get valuable educational materials, including:

- Guidelines for a healthy pregnancy and baby.
- Information on health issues that can impact pregnant women and their babies, including stress, depression and gum disease.
- A guide to pregnancy-related topics available through the CIGNA HealthCare 24-Hour Health Information Line.SM
- A list of informative online and telephone resources.
- Information on prenatal care from the March of Dimes[®] - a recognized source of information on pregnancy and babies.

In addition, you'll have round-the-clock access to a toll-free information line staffed by experienced registered nurses. You may also be eligible for support from a registered nurse case manager if you or your baby has special health care needs.

To enroll, just call the toll-free number on your CIGNA HealthCare ID card, any time during your pregnancy.

Please note: The Healthy Babies program is offered in addition to the services covered as part of a CIGNA HealthCare medical benefit plan. Covered services depend on the CIGNA HealthCare plan offered by your employer.



CIGNA Healthy Pregnancies, Healthy BabiesSM

CIGNA Healthy Pregnancies, Healthy Babies provides tools and information to help enhance the chances for a healthy pregnancy and a healthy baby. The program includes:

- Pre-conception planning and education.
- Risk screenings throughout the pregnancy.
- Personalized, ongoing care management to manage developing risks, and education and self-care tools on a range of topics, including nutrition, exercise, smoking cessation, and more.

To encourage you to make healthy choices, the program includes rewards for enrolling and participating.

If you actively participate in this program through the end of your pregnancy and any postpartum care, you will receive:

\$150 if you enroll in your first trimester.

\$75 if you enroll in your second trimester.

For more information and instructions on enrolling, just call the toll-free number on your CIGNA HealthCare ID card.

CIGNA Comprehensive Oncology ProgramSM

The CIGNA Comprehensive Oncology Program promotes cancer prevention and early detection through support and education.

The program is designed to identify members at risk and provide access to resources that can help them manage the physical, emotional and social aspects of the condition.

Members receive educational materials, personalized care management plans, and continued support and follow up.

For more information, just call the toll-free number on your CIGNA HealthCare ID card.

Convenience Care Clinics

When you need treatment for common ailments such as strep throat, the flu, or pinkeye, convenience care clinics allow convenient and quick access to a clinician for patients who are at least 18 months old.

Located in retail outlets, such as drug stores and department stores, convenience care clinics are generally open seven days a week, with evening hours on weekdays. Please visit our online provider directory on myCIGNA.com (or call Member Services) to see if there is a participating convenience care clinic in your area.

Convenience care clinics are staffed by certified nurse practitioners and/or physician assistants. No appointment is necessary. Primary Care Physician office visit copayment, or coinsurance will apply.

Convenience care clinics focus on a specific number of routine conditions that are generally easy to diagnose and treat. Many diagnoses are not treated at convenience care clinics and will require treatment in a doctor's office or other appropriate setting. **In an emergency, go immediately to the nearest emergency facility or call 911 or your local emergency services number.**

CIGNA Behavioral Advantage

CIGNA Behavioral Advantage emphasizes the mind-body connection and helps you take control of your health and wellness. Medical and mental health case managers' work together to support you on your path to wellness. For example, if you suffer a debilitating illness, we coordinate care to help you cope with the anxiety and depression that often accompany-and complicate-major illness.

CIGNA Behavioral Advantage also offers access to tools that empower you to take charge of your own health and life-whether you want to hash out a problem with the help of a counselor, learn about stress management, or find reliable day care.

To access CIGNA Behavioral Advantage, simply call the toll-free number on your CIGNA HealthCare ID card. You also can find more information under "Related Health Resources" on the myCIGNA.com medical page.

What's in it for you?

Member Assistance Program

When you face a problem or crisis, the Member Assistance Program offers:

- help and support with a range of issues e.g., stress, depression, substance abuse, and marital problems.
- up to three face-to-face sessions with a licensed mental health provider at no charge.



- access to the Life Events Program, providing information, community resources, and referrals on a range of topics, such as finding child care, accessing senior care, or researching adoption alternatives.

Just call the toll-free number on your CIGNA HealthCare ID card and follow the prompts to speak with a 24-Hour Health Information Line nurse.

Enhanced Online Tools

Visit “Related Health Resources” on the myCIGNA.com medical page for:

- information about your benefits, health and well-being articles, in-network providers, and treatment options.
- self-assessment tools.
- an extensive library of information about various medical and behavioral health topics.
- online coaching, one-on-one guidance and support from a licensed behavioral health professional, available through CIGNA Behavioral Health.

CIGNA Well Aware for Better Health®

Your CIGNA HealthCare plan includes CIGNA Well Aware for Better Health. The program offers valuable, confidential support for you and your covered family members with specific medical conditions. Educational materials help you learn more about your health condition, and we also provide regular reminders of important checkups and tests. In addition, we keep your doctor advised of the latest care and treatment techniques.

CIGNA Well Aware for Better Health helps you and your doctor follow your condition more closely and treat it more effectively, so you’ll enjoy life to the fullest. Best of all, this important program is available at no additional cost to you.

Programs are available for the following condition(s):

- Asthma
- Diabetes
- Low Back Pain
- Heart Disease (cardiac)
- Chronic Obstructive Pulmonary Disease
- Depression

- Obesity
- Acid-related stomach disorders
- Atrial fibrillation (irregular heart beat)
- Decubitus ulcer (pressure sores)
- Fibromyalgia
- Hepatitis C
- Inflammatory bowel disease
- Irritable bowel syndrome
- Osteoarthritis
- Osteoporosis
- Urinary incontinence

The program includes a number of services designed to help you better understand and manage your condition:

- Access to registered nurses who specialize in your condition.
- Information and resources that include assistance with self-care materials and services; and informative topic sheets on a variety of condition related topics.
- Reminders of self-care routines, exams and doctor appointments and other important topics.

Throughout the program, you follow your physician’s direction and treatment plan. Meanwhile, both you and your doctor have the added support of a team of health care professionals led by registered nurses who specialize in your condition.

For more information, just call the toll-free number on your CIGNA HealthCare ID card.

Our Commitment to Quality

One of our goals is to work with participating physicians to provide you with access to quality care and programs. The CIGNA HealthCare Quality Management Program is based on industry standards and objective measures that help us evaluate the quality of care and services members receive. The program also helps us better focus our improvement efforts. The program allows for input from our members and providers on:

- Credentialing process for qualified physicians



- Ongoing assessment of clinical activities and services
- Utilization Management activities and programs
- Communicating and administering member Rights and Responsibilities

Various quality committees evaluate the findings to identify improvement opportunities and efficiently monitor change.

You have the right to participate in developing plan policy. You may do so by writing or calling us at the address or telephone number on your CIGNA HealthCare ID card with your opinions, ideas and thoughts. Additionally, your participation in plan surveys gives direct feedback on plan performance and policy developments.

Each year, we evaluate our program to determine our success and identify opportunities for further improvement to focus on for the following year. For information on the CIGNA HealthCare Quality Management Program and/or the annual program evaluation, please call the number on your CIGNA HealthCare ID card.



GROUP SERVICE AGREEMENT





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 for certain Covered Services and Supplies. The Copayment may be a fixed dollar amount or a percentage of the Participating Providers negotiated charge. When the Participating Provider has contracted with the Healthplan to receive payment on a basis other than a fee-for-service amount, the charge may be calculated based on a Healthplan-determined percentage of actual billed charges.

Custodial Services

Any services that are of a sheltering, protective or safeguarding nature. Such services may include a stay in an institutional setting, at-home care or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services given mainly to maintain the person's current state of health. These services cannot be intended to greatly

improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself.

Custodial Services include but are not limited to:

- services related to watching or protecting a person;
- services related to performing or assisting a person in performing any activities of daily living, such as: a) walking, b) grooming, c) bathing, d) dressing, e) getting in or out of bed, f) toileting, g) eating, h) preparing foods, or i) taking medications that can be self administered, and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

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.

Experimental, Investigational and Unproven Services

The 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:

1. not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified by the United States Pharmacopoeia Dispensing



I. Definitions of Terms Used In this Group Service Agreement

Information or the American Hospital Formulary Service;

2. the subject of review or approval by an Institutional Review Board for the proposed use;
3. the subject of an ongoing clinical trial that meets the definition of a phase I or II Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight; or
4. 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.

This definition shall not be used to exclude coverage of any FDA-approved drug on the basis that such drug has been prescribed for the treatment of a type of cancer for which it has not been approved by the FDA, provided the drug is recognized for treatment of the specific type of cancer for which it is prescribed in one of the following established reference compendia: (1) The U.S. Pharmacopeia Drug Information Guide for the Health Care Professional (USP DI); (2) The American Medical Association's Drug Evaluations (AMA DE); or (3) The American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information (AHFS-DI). Coverage shall not be provided for any drug which the FDA has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

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.

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.

Medically Necessary/Medical Necessity

“Medically necessary” or “medical necessity” means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient’s illness, injury or disease; and
3. Not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

For the purposes of this definition, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.



I. Definitions of Terms Used In this Group Service Agreement

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).

Mental Health and Substance Abuse

Mental Health and Substance Abuse Services are defined in “Section IV. Covered Services and Supplies.”

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.

Other Participating Health Care Facility

Other Participating Health Care Facilities are any facilities other than a Participating Hospital or hospice facility which is operated by or has an agreement with HealthPlan to render services to Members. Other Participating Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, authorized residential mental health treatment facilities for children and adolescents, 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 Covered 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.

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.



I. Definitions of Terms Used In this Group Service Agreement

Qualified Medical Child Support Order

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or custody transfer or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

- The order recognizes or creates a child’s right to receive group health benefits for which a participant or beneficiary is eligible;
- The order specifies your name and last known address, and the child’s name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child’s mailing address;
- The order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- The order states the period to which it applies; and
- If the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such notice meets the requirement above.

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.

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. It is the Subscriber's responsibility to maintain a record of Copayments which have been paid and to inform the Healthplan when the amount reaches the Total Copayment Maximums. 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 Connecticut, Inc.

You/Your

The Subscriber and/or any of his Dependents.



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. 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; 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, legally placed with the Subscriber for adoption, or supported pursuant to a court order imposed on the Subscriber (including a qualified medical child support order), 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) and
 - i. has not yet reached age nineteen (19); or
 - ii. if the child is a full-time registered student in regular attendance at a secondary school, college or university, has not yet reached age twenty-three (23). If the school is located outside the Service Area, he is still eligible to enroll and will be covered for Emergency Services and Urgent Care benefits while at school; or

- iii. the child is nineteen (19) or older and continuously incapable of self-sustaining support because of mental or a physical handicap which existed prior to attaining nineteen (19) 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) and (ii) above. We may, from time to time during the next two (2) years, require proof of the continuation of the child's condition and dependence. Thereafter, we may require such proof only once a year.

A Subscriber's grandchild is not eligible for coverage unless they meet the eligibility criteria for a Dependent.

A child born of a Member, when that Member is acting as a surrogate parent, is not eligible for coverage.

Federal rights may not be available to Civil Union partners or Dependents.

Connecticut law grants parties to a civil union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons under federal law may not be available to parties to a civil union.

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C. To be eligible to enroll as a domestic partner, you must:

1. share a permanent residence with the Subscriber;
2. have resided with the Subscriber for not less than one year;
3. be at least eighteen years of age;
4. be financially interdependent with the Subscriber and have proven such interdependence by providing documentation of at least two of the following arrangements:



II. Enrollment and Effective Date of Coverage

- a. common ownership of real property or a common leasehold interest in such property;
 - b. common ownership of a motor vehicle;
 - c. a joint bank account or a joint credit account;
 - d. designation as a beneficiary for life insurance or retirement benefits or under the Subscriber’s last will and testament;
 - e. assignments of a durable power of attorney or health care power of attorney; or
 - f. such other proof as is considered by the Healthplan to be sufficient to establish financial interdependency under the circumstances of a particular case.
5. not be a blood relative any closer than would prohibit legal marriage;
 6. have signed jointly with the Subscriber a notarized affidavit in form and content which is satisfactory to the Healthplan and make this affidavit available to the Healthplan; and
 7. have registered with the Subscriber as domestic partners if you reside in a state that provides for such registration.

Same and opposite sex partners are eligible to enroll as a domestic partner. You are not eligible to enroll as a domestic partner if either you or the Subscriber has signed a domestic partner affidavit or declaration with any other person within twelve months prior to designating each other as domestic partners under this Agreement; are currently legally married to another person; or have any other domestic partner, spouse or spouse equivalent of the same or opposite sex.

An eligible domestic partner’s children who meet the Dependent eligibility requirements in “Section II. Enrollment and Effective Date of Coverage” are also eligible to enroll.

The “Continuation of Group Coverage under COBRA” section of this Agreement does not apply to the Subscriber’s domestic partner and his Dependents.

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 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. 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, 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



II. Enrollment and Effective Date of Coverage

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 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. 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.

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



II. Enrollment and Effective Date of Coverage

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 “Section VII. Termination of Your Coverage” and
2. not have any unpaid financial obligations to the Healthplan or any other CIGNA HealthCare Healthplan.



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 myCIGNA.com.
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."

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 must choose a Primary Care Physician (PCP). Each covered Member of your family also must choose 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. 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 effective on July 1. If you notify us on June 15, the change will be effective on August 1.

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.



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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.

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.

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

9. 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



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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).

The Healthplan assesses providers through review of:

- (1) peer and utilization management data;
- (2) member satisfaction survey results; and
- (3) record audits and other studies about quality of care and service.

10. Payment of Non-contracted Providers

Non-participating providers are paid by the Healthplan for authorized services. Payment may be:

- 1. the generally prevailing fee-for-service rate in the area; or
- 2. other payment method agreed to by the Healthplan and provider.

11. How to Obtain Additional Coverage and Benefit Information

For additional information about your benefits, the Healthplan administrative procedures, and pre-authorization requirements call:

Monday through Friday from 8 am to 5 pm:

- 1. the 800 number on your identification card; or
- 2. the Healthplan 800 number (1-800-345-9458)

After hours and on weekends, call the number on your identification card or the Healthplan 800 number (1-800-345-9458).

12. Information About the Healthplan

Accreditation Status

The Healthplan participates in National Committee for Quality Assurance (NCQA) accreditation surveys and has in the past maintained “Excellent” NCQA accreditation. For current information, please refer to the National Committee for Quality Assurance (NCQA) website at www.ncqa.org. NCQA is a nationally known, independent, non-profit accreditation organization. With employer, union, and health plan input, NCQA developed quality standards in six areas. NCQA uses these standards to assess the quality of services and care.

Accreditation provides consumers with one way to compare health plans.

Pre-authorization Results

In 2005, the Healthplan responded to 10,101 pre-authorization requests. Of these requests, 6,624, or 66%, were approved and 3,477 were denied. Of these denials, 1 was appealed. After review 28 of the denials were reversed or other solutions identified.

Member Satisfaction Survey Results*

2005 Survey results showed:

- 73.4% of Members were satisfied with the overall quality of care and services from their Primary Care Physician (“personal physician or nurse”);
- 30.6% of Members have recommended the Healthplan to some one else; and
- 76.8% of Members were satisfied with the Healthplan.

* Results were based on the top three categories of the survey questionnaire answers.

Medical Loss Ratio

Is a number that tells you what portion of premium payments:



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1. goes to paying for health care services; and
2. what portion goes to cover administrative costs.

The number is generally expressed a percentage. As of December 2005 the Healthplan's medical loss ratio was 86.66%. This means that 86.6 cents out of every paid premium dollar went to paying for health care services and about 13.4 cents went to administrative costs.

State Consumer Report Card

The Insurance Commissioner in consultation with the Commissioner of Public Health, develops and distributes a consumer report card on all Managed Care Organizations. This consumer report card is in a format that allows consumer comparison across Managed Care Organizations.

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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.
10. Make recommendations regarding our policies on Member rights and responsibilities. If you have recommendations, please contact Member Services at the toll-free number on your CIGNA HealthCare ID card.

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.



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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. Understand your health condition and work with your doctor to develop treatment goals that you both agree upon, to the extent that this is possible.
6. Provide honest, complete information to the providers caring for you.
7. Know what medicine you take, why, and how to take it.
8. Pay all Copayments for which you are responsible at the time the service is received.
9. Keep scheduled appointments and notify the doctor's office ahead of time if you are going to be late or miss an appointment.
10. Pay all charges for missed appointments and for services that are not covered by your plan.
11. Voice your opinions, concerns or complaints to CIGNA HealthCare Member Services and/or your provider.
12. 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 Concern or Complaint

(For the purposes of this section, any reference to "you", "your" or "Member" also refers to a



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representative or provider designated by you to act on your behalf, unless otherwise noted.)

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

Start with Member Services

We're here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call us at our toll-free number and explain your concern to one of our Member Services representatives. You can also express that concern in writing. Please call or write to us at the following:

CIGNA HealthCare of Connecticut, Inc.
National Appeals Unit (NAU)
P. O. BOX 5225
Scranton, PA 18505-5225

Member Services Toll-Free Number that appears on your CIGNA HealthCare ID card or benefit Identification card

We'll do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we'll get back to you as soon as possible, but in any case within thirty (30) days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

The Healthplan has a two step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing at the address shown above within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by calling the toll-free number on your CIGNA HealthCare ID card or Benefit Identification card.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial

decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a physician in the field related to the care under consideration, under the authority of a Connecticut-licensed practitioner.

For level one appeals, we will respond in writing to you or your representative and the provider of record with a decision within fifteen (15) calendar days after we receive an appeal for a pre-service or concurrent coverage determination, and within thirty (30) calendar days after we receive an appeal for a post-service coverage determination. If more time or information is needed to make a pre-service or concurrent coverage determination, we will notify you in writing to request an extension of up to fifteen calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient hospital stay. The Healthplan Medical Director, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within the lesser of seventy-two (72) hours after the appeal is received, or two (2) business days after the required information is received, followed up in writing.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To initiate a level two appeal, follow the same process required for a level one appeal.

For post-service claim or administrative appeals, your request must be received before the 14th calendar day following our certified mailing of the Level One determination. All post-service claim or administrative appeals will be reviewed and the decision made by someone who was not



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involved in either the initial or the level one appeal decision.

Most requests for a second reviews of Medical Necessity or clinical appropriateness issues will be conducted by the Appeals Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Appeals committee. The committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by the Healthplan Medical Director. You may present your situation to the committee in person or by conference call.

We will acknowledge in writing that we have received your level two post-service claim or administrative appeal. For level two appeals involving Medical Necessity, we will write to you to schedule a committee review.

If the level two appeal involves pre-service and concurrent care coverage determinations the level two review will be completed within fifteen (15) calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to fifteen (15) calendar days and to specify any additional information needed to complete the review.

For post-service claim or administrative appeals, the level two review will be completed no later than sixty (60) calendar days after receipt of your original Level One request for appeal, unless you request an extension. If we receive a request for a Level Two post-service claim appeal on or after the 14th calendar day following our certified mailing of the Level One determination: (a) it will be deemed as a request by you for an extension; and (b) the sixty-day review period will be suspended on the 14th day we receive no Level Two appeal, then resume on the day we receive your Level Two appeal.

You or your representative and the provider of record will be notified in writing of the level two appeal review decision within five (5) business days after the decision is made, and within the committee review time frames above if the requested coverage is not approved.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient hospital stay. The Healthplan Medical Director, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within the lesser of seventy-two (72) hours or two (2) business days after the required information is received, followed up in writing.

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Appeal to the State of Connecticut

If you are dissatisfied with the decision of the Healthplan's Level Two Appeals Committee regarding Medical Necessity or clinical appropriateness you, or your provider with your consent, may file a written appeal for review with the State of Connecticut, within sixty (60) days after the Level Two Appeal determination. External appeals must be submitted within sixty (60) days after receiving the Level Two Committee determination, on a prescribed state form, with fee of \$25, which is refundable to the prevailing party upon completion of a full review and which may be waived in cases of financial hardship. The Member's submission must also include an executed medical release form, an evidence of coverage, and evidence that the internal appeal process was exhausted.

The Connecticut Insurance Department will assign an impartial external review entity to make a determination within 30 days (or longer, if a review extension is granted by the Dept. and communicated to the Member). The External review decision is binding on Healthplan.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan



III. Agreement Provisions

provisions on which the determination is based; (3) 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; (4) a statement describing: (a) the procedures to initiate the next level of appeal; (b) any voluntary appeal procedures offered by the plan; and (c) the claimant’s right to bring an action under ERISA section 502(a); (5) 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 adverse determination regarding your appeal, and 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.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the Level Two Appeal decision (or with the Level One Appeal decision if expedited). 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.

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.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against HEALTPLAN until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

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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 may require Prior Authorization include inpatient hospital services, inpatient services at any Other Participating Healthcare Facility, Outpatient Facility and Home Health Services, advanced radiological imaging and diagnostics, treatments and procedures including Experimental/Investigational and Unproven services, medications and devices, rehabilitation and therapies, non-emergency ambulance, and 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.

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 for Emergency Services, but you do need to call your PCP or the CIGNA HealthCare 24-Hour Health Information LineSM as soon as possible for further assistance and advice on follow-up care. If you require specialty care or a hospital admission, your PCP or the CIGNA HealthCare 24-Hour Health Information LineSM 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.



IV. Covered Services and Supplies

Emergency Services are defined as the medical, psychiatric, surgical, hospital and related health care services and testing, including ambulance service, 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 serious medical complications, loss of life or permanent impairment to bodily functions 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. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital on the UB92 claim form or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.

Urgent Care Inside the Service Area. For Urgent Care inside the Service Area, you must take all reasonable steps to contact the CIGNA HealthCare 24-Hour Health Information LineSM or 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 LineSM 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 determined by the Healthplan Medical Director in accordance with generally accepted medical standards to have been necessary to treat a condition requiring prompt medical attention. 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 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 or follow-up treatment, whether in or out of the Service Area, is not covered unless it is provided or arranged for by your PCP, a Participating Physician or upon Prior Authorization of 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. Coverage for Emergency Services and Urgent Care received through non-Participating Providers shall be limited to covered services to which you would have been entitled under this Agreement, and shall be reimbursed at the prevailing rate for self-pay patients in the area where the services were provided.

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Ambulance Service

Ambulance services to the nearest appropriate provider or facility.

Anesthesia for Dental Procedures

Coverage for general anesthesia, nursing and related hospital services provided in conjunction with inpatient, outpatient or one-day dental services shall be provided if: (a) the services are deemed medically necessary by the treating dentist or oral surgeon and the Member's Primary Care Physician; and (b) the patient is either 1) determined by a dentist, in conjunction with a Primary Care Physician to have dental condition that requires procedures performed in a hospital; or 2) a person who has a



IV. Covered Services and Supplies

developmental disability determined by the Primary Care Physician to place the person at serious risk

Craniofacial Disorders

Coverage for medically necessary orthodontic processes and appliances for the treatment of craniofacial disorders shall be provided for individuals eighteen years of age or younger, if such processes and appliances are prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association. No coverage shall be provided for cosmetic surgery.

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.

Cancer Clinical Trials

Covered Trials

An organized, systematic, scientific study of:

- (a) therapies, tests, or clinical interventions for purpose of treatment or palliation of cancer in humans, including phase I, phase II and phase III trials; or
- (b) therapeutic intervention for the prevention of cancer in humans which are phase III clinical trials approved by one of the entities listed below, and which are conducted at multiple institutions.

Covered trials must be conducted under auspices of an independent peer-reviewed protocol reviewed and approved by: (1) one of the National Institutes of

Health; or (2) a National Cancer Institute affiliated cooperative group; or (3) the federal FDA as part of an investigational new drug or device exemption; or (4) the federal Department of Defense or Veterans Affairs.

Coverage is not provided for trials conducted solely under approval of the institutional review board of an institution, or for trials no longer approved by an entity listed above.

Covered Patients

You, or the entity conducting the trial, must demonstrate the following:

1. evidence that You meet all patient selection criteria for the trial, including clinical or pre-clinical data showing that the trial is likely to have a benefit commensurate with the risks of participation to treat Your condition;
2. evidence that appropriate informed consent has been received from You;
3. copies of any medical records, protocols, test results, or other clinical information used by the physician or institution seeking to enroll You;
4. a summary of the anticipated routine patient care costs in excess of the costs for standard treatment;
5. information from the physician or institution regarding items, including routine patient care costs which are eligible for reimbursement by entities other than Healthplan, including the trial sponsor; and
6. any additional information reasonably required for the review of the request.

We will request any missing information about the trial within 5 business days after receiving the request for coverage.

Covered Routine Patient Care Costs

“Routine patient care costs” means:

1. Costs for medically necessary services incurred as a result of the treatment provided for the purposes of a cancer clinical trial. Such services must be otherwise covered under the Agreement if not rendered pursuant to a cancer clinical trial, and/or if You were not enrolled in the trial. Such services shall include physician, diagnostic or



IV. Covered Services and Supplies

laboratory testing, hospitalization and other services provided to the patient during the course of treatment for a condition, or one of its complications, and must be consistent with the usual and customary standard of care.

- Costs incurred for drugs which are recognized for the treatment of a specific type of cancer in one of the following established reference compendia: (a) The U.S. Pharmacopeia Drug Information Guide for the Health Care Professional (USP DI); (b) The American Medical Association's Drug Evaluations (AMA DE); or (c) The American Society of Hospital Pharmacist's American Hospital Formulary Service Drug Information (AHFS-DI). Coverage is not required if such drugs are experimental or investigational, and/or are contraindicated by the FDA for treatment of the specific type of cancer being treated.

Routine patient care costs shall not include:

- costs for any new drug or device not approved for market for any indication by the FDA;
- costs for any non health care service that You may be required to receive as a result of the treatment provided;
- facility, ancillary, professional services and drug costs that are paid for by grants or funding for the cancer clinical trial;
- costs of any services that (a) are inconsistent with widely accepted and established regional/national standards of care for a particular diagnosis; or (b) are performed specifically to meet the requirements of the cancer clinical trial;
- costs not covered under the plan for non-investigational treatments, including but not limited to items excluded under the Agreement; and
- transportation, lodging, food or any other expenses associated with travel to or from the facility providing the cancer clinical trial.

Routine patient care costs shall be subject to the terms, conditions, restrictions, exclusions and

limitations that apply for other medical conditions under the Agreement, except that:

- hospitalization shall include treatment at a non-Participating facility if such treatment is (a) not available at a Participating facility and (b) not eligible for reimbursement by the sponsors of such clinical trial; and
- coverage for such non-Participating facility treatment shall be provided at no greater cost to the Member than if such treatment was received from a Participating facility.

Cancer Screening Services

Prostate Cancer Screening. Laboratory and diagnostic tests, including but not limited to prostate specific antigen (PSA) tests, to screen for prostate cancer shall be provided for men: (a) under age 50 who are symptomatic; (b) whose biological father or brother has been diagnosed with prostate cancer; and (c) 50 years of age or older.

Colorectal Cancer Screening. Covered screening shall include, but not be limited to: (1) an annual fecal occult blood test; (2) colonoscopy, flexible sigmoidoscopy or radiologic imaging, in accordance with American College of Gastroenterology recommendations after consultation with the American Cancer Society, based on the ages, family histories & frequencies provided in the recommendations.

Child Early Intervention Services

Medically Necessary early intervention program services provided as part of an individualized family service plan approved by the Connecticut Department of Mental Retardation, and rendered by a program-qualified provider. Covered services include initial child assessment and program-approved services for family members. Dependent children will be covered from birth until thirty six (36) months.

Child Cancer Treatment Assessment

For each Dependent child diagnosed with cancer on or after January 1, 2000, neuropsychological testing ordered by a licensed physician to assess the extent of any cognitive or developmental delays in such child due to chemotherapy or radiation treatment.



IV. Covered Services and Supplies

Diabetic Services and Supplies

Diabetic services and supplies for the treatment of insulin-dependent, insulin-using, gestational, and non-insulin using diabetics, including equipment, drugs, supplies and laboratory and diagnostic tests.

Outpatient self-management training, including, but not limited to, education and medical nutrition therapy, prescribed by a licensed health care professional who has appropriate state licensing authority to prescribe such training. Diabetes self-management training shall be provided by an Other Participating Health Professional trained in the care and management of diabetes and authorized to provide such care within the scope of his/her practice.

Training shall consist of: (1) initial training visits provided to an individual after the individual is initially diagnosed with diabetes that is medically necessary for the care and management of diabetes, including, but not limited to, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes, totaling a maximum of ten (10) hours; (2) training and education that is medically necessary as a result of a subsequent diagnosis by a physician of a significant change in the individual's symptoms or condition which requires modification of the individual's program of self-management of diabetes, totaling a maximum of four (4) hours; and (3) training and education that is medically necessary because of the development of new techniques and treatment for diabetes totaling a maximum of four (4) hours.

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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. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the Healthplan Medical Director.

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, respirators, wheel chairs and dialysis machines.

Durable Medical Equipment items that are not covered, include but are not limited to those items listed below.

- **Bed related items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including non-power mattresses, custom mattresses and posturepedic mattresses.
- **Bath related items:** bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats and spas.
- **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized - manual hydraulic lifts are covered if patient is two person transfer) and auto tilt chairs.
- **Fixtures to real property:** ceiling lifts and wheelchair ramps.
- **Car/van modifications.**
- **Air quality items:** room humidifiers, vaporizers, air purifiers and electrostatic machines.
- **Blood/injection related items:** blood pressure cuffs, centrifuges, nova pens and needle-less injectors.
- **Other equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adapters, Enuresis alarms, magnetic equipment, scales (baby and adult), pressure gradient custom fitted compression stockings, stair gliders, elevators, saunas, any exercise equipment and diathermy machines.



IV. Covered Services and Supplies

External Prosthetic Appliances and Devices

The initial purchase and fitting of external prosthetic appliances and devices that are ordered by a Participating Physician, available only by prescription and are necessary for the alleviation or correction of illness, injury or congenital defect, except as provided in the “Breast Reconstruction and Breast Prostheses” and “Leukemia Treatment (including treatment of tumors)” sections of “Section IV. Covered Services and Supplies.”. Coverage for External Prosthetic Appliances and Devices is limited to the most appropriate and cost effective alternative as determined by the Healthplan Medical Director.

External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices, braces and splints.

Prostheses/Prosthetic Appliances and Devices

Prostheses/Prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

- Basic limb prostheses;
- Terminal devices such as hands or hooks; and
- Speech prostheses.

Orthoses and orthotic devices

Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- 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 orthoses 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 orthosis is an integral part of a leg brace, and it is necessary for the proper functioning of the brace;
- c. When the foot orthosis 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; and
- 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 orthosis and orthotic devices:

- Prefabricated foot orthoses;
- Cranial banding/cranial orthoses/other similar devices are excluded, except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- Orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- Orthoses primarily used for cosmetic rather than functional reasons; and
- Orthoses primarily for improved athletic performance or sports participation.

Braces

A brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

The following braces are specifically excluded:

- Copes scoliosis braces.



IV. Covered Services and Supplies

Splints

Splints are defined as an appliance for preventing movement of joints or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- Replacement due to regular wear. Replacement for damage due to abuse or misuse by the member will not be covered; and
- Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.

Coverage for replacement is limited as follows:

- No more than once every 24 months for Members 19 years of age and older;
- No more than once every 12 months for Members 18 years of age and under; and
- Replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:

- External and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- Myoelectric prosthesis peripheral nerve stimulators.

Genetic Testing

Genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is only covered if:

- You have symptoms or signs of a genetically-linked inheritable disease;
- It has been determined that you are at risk for carrier status as supported by existing peer-reviewed, evidence-based scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- The therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if you are undergoing approved genetic testing, or if you have an inherited disease and are a potential candidate for genetic testing. Genetic counseling is limited to three (3) visits per Contract Year for both pre- and post-genetic testing.

Hearing Aids for Children

Hearing aids for children twelve (12) years of age or younger. Benefits are limited to \$1,000 within a twenty-four (24) month period.

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 and/or Custodial Services (e.g. bathing, eating, toileting), home health services will only be provided for you during times when there is

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).



IV. Covered Services and Supplies

a family member or care giver present in the home to meet your non-skilled care and/or Custodial Services needs.

Home health services are those skilled health care services that can be provided during visits by Other Participating Health Care 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. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations. A home health aide visit is defined as a period of four (4) hours or less. Necessary consumable medical supplies, and home infusion therapy administered or used by Other Participating Health Care 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.

Physical, occupational and other Short-term Rehabilitative Therapy services provided in the home only count towards home health care maximums if the services are given in accordance with an approved treatment plan and commencing within seven days of a hospital stay and provided by a home health care agency.

If the above provision is not met, Physical, occupational, and other Short-term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services and benefit limitation in the Schedule of Copayments, but are subject to the benefit limitations described under "Short-term Rehabilitative Therapy" in the Schedule of Copayments.

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 and treatment of infertility and treatment of infertility once a



IV. Covered Services and Supplies

condition of infertility has been diagnosed. Services include, but are not limited to: infertility drugs which are administered or provided by the Participating Provider, approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests, sperm washing or preparation, diagnostic evaluations, gamete intrafallopian transfer (GIFT), in vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), low tubal ovum transfer, and the services of an embryologist including but not limited to uterine embryo lavage and embryo transfer.

Services also include ovulation induction for no less than a lifetime maximum benefit of four cycles, and intrauterine insemination up to a lifetime maximum benefit of three cycles.

Coverage for in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) and low tubal ovum transfer services is limited to those individuals who are unable to conceive or sustain a successful pregnancy through less expensive and medically viable (as determined by the individual's physician) treatments or procedures covered under the Agreement, for no less than a combined lifetime maximum benefit of two cycles with not more than two transfers per cycle.

The lifetime maximum benefits above are determined by all treatments provided in a covered person's lifetime while the person has been continuously covered (no break in coverage) under this Group Agreement, beginning on the first Agreement effective date or renewal date on or after October 1, 2005.

Coverage for infertility services is subject to prior authorization. Covered infertility treatment must be performed at facilities that conform to the standards and guidelines developed by the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility.

Infertility is defined as the condition of a presumably healthy individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one-year period.

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

- Reversal of male and female voluntary sterilization;
- Infertility services when the infertility is caused by or related to voluntary sterilization;
- Donor charges and services;
- Cryopreservation of donor sperm and eggs;
- gestational carriers and surrogate parenting arrangements; and
- Any experimental, investigational or unproven 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 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 provide permanent or temporary internal functional supports for non-functional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

Laboratory and Radiology Services

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

Leukemia Treatment

Coverage for treatment of leukemia, including outpatient chemotherapy, reconstructive surgery, cost of any non-dental prosthesis, including any maxillo-facial prosthesis used to replace anatomic structures lost during treatment for head and neck tumors or additional appliances essential for the support of such prosthesis, outpatient chemotherapy following surgical procedures in connection with the treatment of tumors and costs of removal of any breast implant, without regard to the purpose of such



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implantation, which removal is determined to be medically necessary.

The coverage shall include benefits for the reasonable costs of reconstructive surgery on each breast on which a mastectomy has been performed, and reconstructive surgery on a non-diseased breast to produce a symmetrical appearance. Such breast reconstructive surgery shall include, but not be limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.

Coverage for treatment of leukemia shall provide at least a yearly benefit of one thousand (\$1,000) dollars for the costs of removal of any breast implant, five hundred (\$500) dollars for the surgical removal of tumors, five hundred (\$500) dollars for reconstructive surgery, five hundred dollars for outpatient chemotherapy and three hundred (\$300) dollars for prosthesis, except that for purposes of the surgical removal of breasts due to tumors the yearly benefit for prosthesis shall be at least three hundred (\$300) dollars for each breast removed.

Lyme Disease Treatment

Coverage for treatment of lyme disease, including up to thirty (30) days of intravenous antibiotic therapy or up to sixty (60) days of oral antibiotic therapy or both, shall be provided as requested or directed by the HealthPlan Medical Director or Primary Care Physician. Coverage for further treatment shall be provided if recommended by a board-certified rheumatologist, infectious disease specialist or neurologist.

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 forty-eight (48) hours of inpatient care following a vaginal delivery and a minimum of ninety-six (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 event that the mother and newborn are discharged prior to 48/96 hours, coverage shall be provided for a follow-up visit within forty-eight (48) hours of discharge and an additional follow-up visit within seven (7) days of discharge. Follow-up visits include, but are not limited to, physical assessment of the newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system and the performance of any appropriate clinical tests.

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Mental Health and Substance Abuse Services

Mental health services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes, as defined under “mental or nervous conditions” in the most recent edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders’. Mental or nervous conditions does not include, mental retardation, learning disorders, motor skills disorder, communication disorders, caffeine-related disorders, relational problems, and additional conditions that may be focus or clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders’. In determining benefits payable, charges made for the treatment of any physiological conditions related to mental health will not be considered to be charges made for treatment of mental health.

Substance abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment as defined under “mental or nervous conditions” in the most recent edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders’. Mental or nervous conditions does not include, mental retardation, learning disorders, motor skills disorder, communication disorders, caffeine-related disorders, relational problems, and additional conditions that may be focus or clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders’. In determining benefits payable, charges made for the treatment of any physiological



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conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of substance abuse.

Inpatient Mental Health Services

Inpatient Services that are provided by a Participating Hospital or Other Participating Health Care Facility for the treatment and evaluation of mental health.

Services are also provided for partial hospitalization sessions of not less than four (4) hours and not more than twelve (12) hours in any twenty-four (24) hour period.

Residential Treatment Services

Services that are provided by an Other Participating Health Care Facility for treatment when a Member: (i) has a serious mental illness which substantially impairs his/her thought, perception of reality, emotional process, or judgement or grossly impairs behavior as manifested by recent disturbed behavior; (ii) has been confined in a hospital for such illness for a period of at least three days immediately preceding such confinement in a residential treatment facility; and (iii) such illness would otherwise necessitate continued confinement in a hospital if such care and treatment were not available through a residential treatment center for children and adolescents. Services must be rendered pursuant to an individual treatment plan, which is prescribed by a physician with specific attainable goals and objectives appropriate to both the Member and the treatment modality of the program.

Outpatient Mental Health Services

Services of Participating Providers who are qualified to treat mental health when treatment is provided on an outpatient basis in an individual, group or Mental Health Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interferes with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective

disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic mental health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

Mental Health Intensive Outpatient Therapy Program

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed mental health program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine (9) or more hours in a week.

Mental Health Intensive Outpatient Therapy Program services are exchanged with Outpatient Mental Health visits at a rate of one (1) visit of Mental Health Intensive Outpatient Therapy being equal to one (1) visit of Outpatient Mental Health Services.

Inpatient Substance Abuse Rehabilitation Services

Services provided by a facility designated by the Healthplan for rehabilitation when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient substance abuse benefits are exchangeable with partial hospitalization sessions when benefits are provided for not less than four (4) hours and not more than twelve (12) hours in any twenty-four (24) hour period. The benefit exchange will be two (2) partial hospitalization sessions are equal to one (1) day of inpatient care.

Substance Abuse Residential Treatment Services

Services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute substance abuse conditions. Substance Abuse Residential Treatment services are exchanged with Inpatient Substance Abuse Rehabilitation services at a rate of two (2) days of Substance Abuse Residential Treatment being equal to one (1) day of Inpatient Substance Abuse Rehabilitation Treatment.



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Substance Abuse Residential Treatment Center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of substance abuse; (b) provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; (c) provides twenty-four (24) hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center. A person is considered confined in a Substance Abuse Residential Treatment Center when he is a registered bed patient in a Substance Abuse Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Abuse Rehabilitation Services

Services for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs including outpatient rehabilitation in an individual or Substance Abuse Intensive Outpatient Therapy Program.

Substance Abuse Intensive Outpatient Therapy Program

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed substance abuse program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine (9) or more hours in a week.

Substance Abuse Detoxification Services

Detoxification and related medical ancillary services when required for the diagnosis and treatment of addiction to alcohol and/or drugs. The Healthplan Medical Director will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Excluded Mental Health and Substance Abuse Services

The following are specifically excluded from Mental Health and Substance Abuse 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;

- Treatment of mental disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain;
- Developmental disorders, including but not limited to developmental reading disorders, developmental arithmetic disorders, developmental language disorders and developmental articulation disorders;
- Counseling for activities of an educational nature;
- Counseling for borderline intellectual functioning;
- Counseling for occupational problems;
- Counseling related to consciousness raising;
- Vocational or religious counseling;
- I.Q. testing;
- Mental Health residential treatment, except as described under the provision entitled "Residential Treatment Services";
- Custodial care, including but not limited to geriatric day care;
- Psychological testing on children requested by or for a school system; and
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

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Nutritional Evaluation

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

Nutritional Formula for Inherited Metabolic Diseases and Specialized Infant Formulas

Amino Acid modified preparations and low protein modified food products prescribed by a Participating Physician for the therapeutic treatment of inherited metabolic diseases. Inherited metabolic disease: (A) means a disease for which newborn screening is



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required; and (B) cystic fibrosis. Low protein modified food product means a product formulated to have less than one gram of protein per serving and intended for the dietary treatment of an Inherited Metabolic Disease. Amino acid modified preparation means a product intended for the dietary treatment of Inherited Metabolic Diseases under the direction of a physician.

Specialized formulas for children up to age twelve when medically necessary for treatment of a specific disease or condition and administered under the supervision of a physician. "Specialized formula" means nutritional formula for children up to age twelve that is exempt from FDA nutritional labeling requirements and is intended for use solely under medical supervision in the dietary management of specific diseases.

Obstetrical and Gynecological Services

Obstetrical and gynecological services that are provided by qualified Participating Providers for pregnancy, well-women gynecological exams including pap smears, 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.

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.

Pain Management

Pain treatment procedures and medications, including all means medically necessary to make a diagnosis and treatment plan. Such procedures or medications must be ordered by a pain management specialist physician who is credentialed by the American Academy of Pain Management or who is a board certified anesthesiologist, neurologist, oncologist or radiation oncologist with additional training in pain management. "Pain" means any sensation in which a person experiences severe

discomfort, distress or suffering due to provocation of sensory nerves.

Reconstructive Surgery

Reconstructive surgery or therapy to repair or correct a severe facial disfigurement which is accompanied by functional deficit (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 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part.

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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Orthognathic Surgery

Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct; provided that:

- the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement, or;
- the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease, or;
- the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

Repeat or subsequent orthognathic surgeries for the same condition are covered only when 1) the previous orthognathic surgery met the above requirements, and 2) there is a high probability of significant additional improvement as determined by the Healthplan Medical Director.

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Short-term Rehabilitative Therapy and Chiropractic Care Services

Short-term rehabilitative therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting. Also included are services that are provided by a chiropractic Physician when provided in an outpatient setting. Services of a chiropractic Physician include the management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment that is rendered to restore motion, reduce pain and improve function.

The following limitation applies to short-term rehabilitative therapy and chiropractic care services:

- Occupational therapy is provided only for purposes of enabling Members to perform the activities of daily living after an illness or an injury.

Short term Rehabilitative Therapy and Chiropractic Care Services that are not covered include, but are not limited to:

- Sensory integration therapy; group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily-acted conditions without evidence of an underlying medical condition or neurological disorder;
- Treatment for functional articulation disorder, such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or injury; and
- Maintenance or preventive treatment consisting of routine, long-term or non-Medically Necessary care provided to prevent reoccurrences or to maintain the patient's current status.

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; and

- Vitamin therapy.

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Transplant Services

Human organ and tissue transplant services at designated facilities throughout the United States. Transplant services include solid organ and bone marrow/stem cell procedures. This coverage is subject to the following conditions and limitations.

Transplant services include the recipient's medical, surgical and hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell 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 intestinal, which includes small bowel, small bowel/liver or multivisceral.

All transplant services other than cornea, must be received at a qualified or provisional CIGNA LIFESOURCE Transplant Network® facility.

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. Costs related to the search and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant Travel Services

Reasonable travel expenses incurred by you in connection with a pre-approved organ/tissue transplant are covered subject to the following conditions and limitations. 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 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)



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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:

- 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 a transplant. No benefits are available where the Member is a donor.

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Vision and Hearing Screenings for Dependents

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

Wigs for Cancer Patients

A yearly benefit as described in the Schedule of Copayments for a wig, if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy.

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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:

4. Care for health conditions that are required by state or local law to be treated in a public facility.
5. Care required by state or federal law to be supplied by a public school system or school district.
6. Care for military service disabilities treatable through governmental services if the Member is legally entitled to such treatment and facilities are reasonably available.
7. Treatment of an illness or injury which is due to war, declared or undeclared.
8. 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, except when such exclusion is prohibited by law.
9. Assistance in the activities of daily living, including, but not limited to, eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
10. Any Services and Supplies for or in connection with 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 demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or
- Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate

regulatory agency to be lawfully marketed for the proposed use; or 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, except as provided in the "Clinical Trials" section of "Section IV. Covered Services and Supplies;" or
 - The subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of "Section IV. Covered Services and Supplies." 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
11. Cosmetic Surgery or Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
 12. The following services are excluded from coverage regardless of clinical indications:
 - Macromastia or Gynecomastia Surgeries;
 - Surgical treatment of varicose veins;
 - Abdominoplasty;
 - Panniculectomy;
 - Rhinoplasty;
 - Blepharoplasty;
 - Redundant skin surgery;
 - Removal of skin tags;
 - Acupressure;
 - Craniosacral/cranial therapy;
 - Dance therapy, movement therapy;
 - Applied kinesiology;



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- Rolting;
 - Prolotherapy; and
 - Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
13. Treatment of TMJ disorder.
 14. 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; except as medically necessary for craniofacial disorders. 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.
 15. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, including clinically severe (morbid) obesity, including: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.
 16. 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.
 17. 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."
 18. Infertility services, when the infertility is caused by or related to voluntary sterilization; donor charges and services; cryopreservation of donor sperm and eggs; gestational carriers and surrogate parenting arrangements, and any experimental, investigational or unproven infertility procedures or therapies.
 19. Reversal of male or female voluntary sterilization procedures.
 20. Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
 21. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
 22. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement or unless the care and costs are incurred for a newly born child within the first thirty-one days after the date of birth.
 23. Non-medical counseling or ancillary services, including, but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety, and services, training educational therapy or other non-medical ancillary services for learning disabilities, developmental delays (other than neuropsychological testing ordered by a licensed physician to assess the extent of any cognitive or developmental delays in a Dependent child due to chemotherapy or radiation treatment), autism or mental retardation.
 24. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
 25. 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"; and except for medically necessary appliances and supplies such as collection devices, irrigation equipment and supplies, skin



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- barriers and skin protectors which are related to an ostomy, colostomy, ileostomy or urostomy surgery.
26. Private hospital rooms and/or private duty nursing except as provided in the "Home Health Services" section of "Section IV. Covered Services and Supplies".
 27. 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.
 28. Artificial aids, including but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs (other than wigs covered for cancer patients as described in "Covered Services and Supplies").
 29. Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
 30. Hearing aids, including but not limited to, semi-implantable hearing devices, audient bone conductors and Bone Anchored Hearing Aids (BAHAs) except as covered under "Hearing Aids for Children". A hearing aid is any device that amplifies sound.
 31. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).
 32. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
 33. Treatment by acupuncture.
 34. All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Section IV. Covered Services and Supplies."
 35. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
 36. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
 37. Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.
 38. Dental implants for any condition.
 39. 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.
 40. Blood administration for the purpose of general improvement in physical condition.
 41. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
 42. Cosmetics, dietary supplements and health and beauty aids.
 43. All nutritional supplements and formulae are excluded except for infant formula needed for the treatment of inborn errors of metabolism and except as covered under "Nutritional Formula for Inherited Metabolic Diseases and Specialized Infant Formulas".
 44. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
 45. Telephone, e-mail and internet consultations and telemedicine.
 46. Massage therapy.
- 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."
- No Covered Services and Supplies may be excluded because they are rendered to treat any injury that is alleged to have occurred or occurs when an insured person has an elevated blood alcohol content level



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(BAC) of 0.08% or more or is under the influence of an intoxicating liquor, drug or both.

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

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.

Nothing in this provision shall be construed to permit any recoveries which are prohibited by Connecticut General Statutes §52-225c, as amended. Healthplan shall provide a copy of said statute to Member upon request.

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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 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



VI. Other Sources of Payment For Services and Supplies

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 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 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



VI. Other Sources of Payment For Services and Supplies

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 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.



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, subject to the provision entitled "Time Limit on Certain Defenses" in Section IX, Miscellaneous;
2. You permit a non-Member to use your CIGNA HealthCare ID card or to falsely obtain Services and Supplies;
3. You obtain or attempt to obtain Services and Supplies by means of false, misleading or fraudulent information, acts or omissions;
4. You fail to pay any Copayment, or any other amount due as a result of receiving Services and Supplies;
5. You fail to establish a satisfactory Physician/patient relationship with any Participating Physician after we assist you in establishing such a relationship;
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; or
7. You threaten the life or wellbeing of any Healthplan employee, Participating Provider, or another Member.

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 Fee. We may terminate this Agreement for the Group's non-payment of any Prepayment Fee owed to us.
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 to all groups in the applicable market in accordance with all state and federal requirements for such discontinuance (this provision does not apply to small group health business unless and until the subject block of business is sold to another carrier); 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.
3. Termination for Fraud or Misrepresentation. We may terminate this Agreement upon thirty (30) days prior written notice to the Group subject to applicable state and federal requirements regarding fraud and time limit



VII. Termination of Your Coverage

on certain defenses, 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.

4. Non-renewal for Violation of Contribution or Participation Rules. We may non-renew 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.
5. Termination Due to Association Membership Ceasing. If this Agreement covers an association, we may terminate this Agreement 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.
6. 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.

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 at least 15 days prior to the termination effective date and the Group shall notify you of 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.

Extension of Benefits Upon Total Disability

Upon termination of this Agreement, an extension of benefits will be provided to you, without premium payment, if you are continuously disabled when this Agreement is terminated. Coverage will be provided for only the disabling condition and will continue until the earliest of:

1. The expiration of twelve (12) months,
2. You are no longer totally disabled,
3. The maximum benefits payable under the Agreement have been exhausted (e.g. Skilled Nursing Facility Services – 100 days per twelve (12) consecutive months.)

Total disability is defined as the complete inability of the Subscriber to perform the substantial and material duties of his/her occupation. Total disability for a dependent means the inability, as a result of injury or illness, to perform the normal activities of a person of like age and sex in good health.

Certification of Creditable Coverage Upon Termination

We will issue you a Certification of Creditable Group Health Plan 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.



VIII. Continuation of Coverage

Section VIII. Continuation of Coverage

Continuation of Group Coverage under COBRA

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan’s Summary Plan Description or get a copy of the Plan Document from the Plan Administrator.

The Plan Administrator information is provided on the page titled “ERISA Summary Plan Description,” if applicable. Please contact the Plan Administrator for the name, address and phone number of the Plan’s COBRA Administrator.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the

Plan because either one of the following qualifying events happens:

- (1) Your hours of employment are reduced, or
- (2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- (1) Your spouse dies;
- (2) Your spouse’s hours of employment are reduced;
- (3) Your spouse’s employment ends for any reason other than his or her gross misconduct;
- (4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- (5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- (1) The parent-employee dies;
- (2) The parent-employee’s hours of employment are reduced;
- (3) The parent-employee’s employment ends for any reason other than his gross misconduct;
- (4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- (5) The parents become divorced or legally separated; or
- (6) The child stops being eligible for coverage under the Plan as a “dependent child.”

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, enrollment of



VIII. Continuation of Coverage

the employee in Medicare (Part A, Part B, or both), or, if the Plan provides retiree coverage, commencement of a proceeding in bankruptcy with respect to the Employer, the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to your Employer.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months from the date of the qualifying event.

When the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage lasts for up to 18 months from the date of the qualifying event. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

If the Plan provides retiree health coverage

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse, surviving spouse and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan. Coverage will continue

until: (a) for you, your death; and (b) for your Dependent surviving spouse or Dependent child, up to 36 months from your death.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months from the date of the initial qualifying event. You must make sure that the Plan Administrator is notified of the Social Security Administration’s determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the Plan Administrator. You must provide a copy of the Social Security Administration’s determination. Termination of coverage for all covered persons during the additional 11 months will occur if the disabled person is found by the Social Security Administration to be no longer disabled. Termination for this reason will occur on the first day of the month beginning no more than 30 days after the date of the final determination. Please refer to “Early Termination of COBRA Continuation” below for additional circumstances under which COBRA continuation may terminate before the end of the maximum period of coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months from the initial qualifying event. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, you must**



VIII. Continuation of Coverage

make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator.

Early Termination of COBRA Continuation

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, if a covered employee enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

Cost of COBRA Continuation Coverage

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150%). If you or your dependents experience a qualifying event, the Plan Administrator will send you a notice of continuation rights, which will include the required premium.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282.

TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at

www.doleta.gov/tradeact/2002act_index.asp.

Conversion Available Following Continuation

If the Plan provides for a conversion privilege, the plan must offer this option within 180 days following the maximum period of continuation. However, no conversion will be provided if the qualified beneficiary does not maintain COBRA continuation coverage for the maximum allowable period or does not otherwise meet the eligibility requirements for a conversion plan.

Service Area Restrictions

This plan includes a service area restriction which requires that all enrolled participants and beneficiaries receive services in the Employer's service area. This restriction also applies to COBRA continuation coverage. If you or your Dependents move outside the Employer's service area, COBRA continuation coverage under your current plan in your new location will be limited to emergency services only. To obtain coverage for non-emergency services, you must obtain such services from a network provider in the Employer's service area. If your Employer offers other benefit options that are available in your new location, you may be allowed to obtain COBRA continuation coverage under that option. If you or your Dependent is moving outside the Employer's service area, please contact your Employer for information on the availability of other plan options.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.



VIII. Continuation of Coverage

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 Group Coverage under Connecticut State Law

Under the requirements of Connecticut State Law, Subscribers and Dependents must be given 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 Connecticut State Law: (a) only to the extent that continuation of coverage is not otherwise provided under COBRA; (b) only if the required premiums are paid when due; and (c) will be subject to future plan changes.

Connecticut Continuation for Non-COBRA Groups

Group plans that are not subject to COBRA must give employees and dependents the right to Connecticut Continuation coverage, which meets all the standards of the COBRA continuation coverage described above; except that:

- Upon an employee's absence from employment due to illness or injury, the employee may continue coverage for himself and/or his dependents for up to 12 months, beginning when the absence begins. Such coverage will continue regardless of eligibility for other group coverage, and will end if the illness or injury condition ends.

In addition to coverage which meets all the standards of the COBRA coverage:

- Upon reduction of hours, leave of absence, or termination of employment due to an employee's eligibility for Social Security income, the employee may continue coverage for himself and/or his dependents until the date the employee becomes eligible for Medicare. In order for this additional coverage to be effective,

the employee must provide the employer with a copy of the Social Security Administration's determination of eligibility for Social Security income within 60 days of receiving such notice. The notice must also be provided to the employer within the initial 18 months of continuation coverage.

Connecticut Continuation for COBRA Groups

Group plans that are subject to COBRA must give employees and dependents the right to the COBRA continuation coverage described above; and:

- Upon reduction of hours, leave of absence, or termination of employment due to a employee's eligibility for Social Security income, the employee may continue coverage for himself and his dependents until the date the employee becomes eligible for Medicare. In order for this additional coverage to be effective, the employee must provide the employer with a copy of the Social Security Administration's determination of eligibility for Social Security income within 60 days of receiving such notice. The notice must also be provided to the employer within the initial 18 months of continuation coverage.

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

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Conversion to Non-Group (Individual) Coverage

If you have properly elected and completed any COBRA continuation or other continuation coverage (i.e. completed the maximum coverage period under the continuation coverage), you may apply to the Healthplan for conversion to non-group (individual) coverage. If you do not elect, fail to properly elect or fail to complete any COBRA continuation coverage or other continuation coverage for which you are eligible, conversion to non-group coverage is not available to you.

You must continue to reside in the Service Area in order to be eligible for non-group (individual)



VIII. Continuation of Coverage

coverage. You may apply for non-group (individual) coverage as follows:

A. Conversion After Loss of Subscriber Eligibility

If you, as the Subscriber, are no longer eligible for coverage under this Agreement for any reason other than the reasons stated in the “Termination for Cause” or “Termination By Termination of Agreement” provisions of “Section VII. Termination of Your Coverage,” you may apply for conversion to non-group (individual) coverage. You must apply and pay the applicable prepayment fee within thirty-one (31) days of the loss of group coverage. At the time of conversion to non-group (individual) coverage, you may also apply for non-group (individual) coverage for Dependents who were Members at the time of your loss of eligibility. If your application and all non-group fees, including all fees for the period since the termination of group coverage, are submitted within thirty-one (31) days of the loss of group coverage, your non-group (individual) coverage will be effective as of the date of such termination.

B. Conversion Upon Death or Divorce of Subscriber

If you are a Dependent who has lost eligibility for coverage under this Agreement due to the death or divorce of the Subscriber, you may apply for conversion to non-group (individual) coverage under the provisions of paragraph A of this section.

C. Conversion Upon Meeting Age Limitation

If you are a Dependent who has lost eligibility for coverage under this Agreement due to your attainment of an age limitation identified in the Agreement, you may apply for conversion to non-group (individual) coverage under the provisions of paragraph A of this section.

D. Conversion After Expiration of COBRA or Other Continuation Coverage

A Member whose COBRA or other continuation coverage has expired after the maximum coverage period may apply for conversion to non-group (individual) coverage under the provisions of paragraph A of this section.

The services and supplies, terms and conditions of the non-group (individual) coverage, including premiums, Copayments and deductibles, if any, shall be in accordance with the rules of Healthplan in effect at the time of conversion and will not necessarily be identical to the services and supplies provided under this Agreement.

Health Reinsurance Association

In addition to the above, you will also be able to convert to the Health Reinsurance Association individual health care plan as described in Connecticut Public Act 93-338.

Continuation of Coverage Under FMLA

If the Group is subject to the requirements of the federal law known as the Family and Medical Leave Act of 1993, as amended (FMLA), 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.

NOTICE OF FEDERAL REQUIREMENTS - UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to military leaves of absence. These requirements apply to medical coverage for you and your Dependents.

Continuation of Coverage

You may continue coverage for yourself and your Dependents as follows:

You may continue benefits, by paying the required premium to your employer, until the earliest of the following:

- 24 months from the last day of employment with the employer;



VIII. Continuation of Coverage

- the day after you fail to apply or return to work;
and
- the date the policy cancels.

Your employer may charge you and your Dependents up to 102% of the total premium.

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any “Conversion Privilege” shown in your Agreement.

Reinstatement of Benefits

If your coverage ends during the leave because you do not elect USERRA, or an available conversion plan at the expiration of USERRA, and you are reemployed by your current employer, coverage for you and your Dependents may be reinstated if, (a) you gave your employer advance written or verbal notice of your military service leave, and (b) the duration of all military leaves while you are employed with your current employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a Pre-existing Conditions Limitation (PCL) or waiting period, if any, that was not yet satisfied before the leave began. However, if an injury or sickness occurs or is aggravated during the military leave, full plan limitations will apply.

Any 63-day break in coverage rule regarding credit for time accrued toward a PCL waiting period will be waived.



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.

Service Marks

The CIGNA HealthCare 24 Hour Health Information LineSM and CIGNA LIFESOURCE Transplant Network[®] are registered service marks of CIGNA Corporation.

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.



Time Limit on Certain Defenses

All statements made by you are considered representations and not warranties, and no statement voids the coverage or reduces the benefits thereunder after this coverage has been in force for two (2) years from the effective date.



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.

Covered Services and Supplies	Copayments
<p>Physician Services</p> <p>Primary Care Physician Office Visit Preventive Care Adult Medical Care Periodic Physical Evaluation for Adults Well-Child Care Routine Immunizations Surgery Performed in the Physician’s Office</p> <p>Specialty Care Physician Office Visit Office Visits Surgery Performed in the Physician’s Office</p>	<p>\$25 Copayment per office visit</p> <p>The office visit Copayment will be waived when immunization is the only service provided</p> <p>The office visit Copayment will be waived for nutritional formula for inherited metabolic disease or specialized infant formula</p> <p>\$35 Copayment per office visit</p> <p>The office visit Copayment will be waived for nutritional formula for inherited metabolic disease or specialized infant formula</p>
<p>Inpatient Hospital Services</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>\$300 Copayment per admission</p>



Schedule of Copayments

Covered Services and Supplies	Copayments
<p>Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, and Treatment Room including Physician and Surgeon Charges Laboratory and Radiology Services Administered Drugs, Medications, Biologicals and Fluids Anesthesia Inhalation Therapy</p>	<p>\$125 Copayment per facility use</p>
<p>Emergency and Urgent Care Services</p> <p>Physician’s Office</p> <p>Hospital Emergency Room</p> <p>Urgent Care Facility or Outpatient Facility</p>	<p>Same as Physician Office Visit Copayment</p> <p>\$100 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>\$25 Copayment per visit</p> <p>The urgent care facility Copayment will be waived if you are admitted to a participating hospital directly from the urgent care facility.</p>
<p>Ambulance Services</p>	<p>No Charge</p>
<p>Child Early Intervention Services Up to three thousand two hundred dollars (\$3,200) per child per year, and nine thousand six hundred dollars (\$9,600) per child over the total three-year period (not applied to any maximum lifetime or annual benefit limits otherwise specified in the plan)</p>	<p>Same as Physician's Office Visit</p>



Schedule of Copayments

Covered Services and Supplies	Copayments
Diabetic Services and Supplies	
Self Management Courses and Training	Same as Physician Copayment
Equipment	Same as Durable Medical Equipment Copayment per item, not to exceed 50% of the cost.
Insulin and other Diabetic Pharmaceutical Supplies	\$10 Copayment per item/prescription, not to exceed 50% of the cost.
Durable Medical Equipment (DME) \$3,500 maximum per Member per Contract Year, maximum does not apply to Hearing Aids for Children.	No Charge
External Prosthetic Appliances \$1,000 maximum per Member per Contract Year, maximum does not apply to external breast prosthesis following surgical removal of breasts due to tumors or wigs for cancer patients.	No Charge
Family Planning Services	
Office Visits (Tests, Counseling)	Same as Physician Office Visit Copayment
Surgical Sterilization Procedures	Same as Inpatient Hospital, Outpatient Facility or Physician Office Visit Copayment, depending on facility used
Hearing Aids for Children \$1,000 maximum benefit per member per twenty-four (24) month period. DME maximum does not apply.	Same as DME copayment per item
Home Health Services * 80 day maximum per member per Contract Year.	No Charge
Hospice Services	
Inpatient Services	No Charge
Outpatient Services	No Charge



Schedule of Copayments

Covered Services and Supplies	Copayments
<p>Infertility Services</p> <p>Physician Office Visit</p> <p>Surgical Treatment</p>	<p>Same as Physician Office Visit Copayment</p> <p>Same as Inpatient Hospital or Outpatient Facility Copayment depending on facility used</p>
<p>Inpatient Services at Other Participating Health Care Facilities</p> <p>60 day maximum per Member per Contract Year</p> <p>Rehabilitation Hospital</p> <p>Skilled Nursing Facility and Sub-Acute Facilities</p>	<p>No Charge</p> <p>No Charge</p>
<p>Outpatient Laboratory and Radiology Services</p> <p>Advanced Radiological Imaging (MRIs, MRAs, CAT scans, PET scans, etc.)</p> <p>Other Laboratory and Radiology Services</p> <p>Outpatient Hospital Facility</p> <p>Independent Facility</p>	<p>No Charge</p> <p>No Charge</p> <p>No Charge</p>
<p>Maternity Care Services</p> <p>Initial Office Visit to Confirm Pregnancy</p> <p>All other Office Visits</p> <p>Delivery</p>	<p>Same as Physician Office Visit Copayment</p> <p>No Charge</p> <p>Same as Inpatient Hospital Copayment</p>
<p>Mental Health and Substance Abuse Services***</p> <p>Inpatient Mental Health Services</p> <p>Outpatient Individual Mental Health Services</p> <p>Outpatient Mental Health Group Therapy</p>	<p>Same as Inpatient Hospital Services</p> <p>Same as Physician’s Office Visit Copayment</p> <p>The greater of one-half (1/2) the Specialty Physician Copayment or \$5 per session</p>



Schedule of Copayments

Covered Services and Supplies	Copayments
Mental Health Intensive Outpatient Therapy Programs	3X Physician's Office Visit Copayment per program
Inpatient Substance Abuse Rehabilitation Services	Same as Inpatient Hospital Services
Outpatient Individual Substance Abuse Rehabilitation Services	Same as Physician's Office Visit Copayment
Substance Abuse Intensive Outpatient Therapy Programs	3X Physician's Office Visit Copayment
Inpatient Substance Abuse Detoxification Services	Same as Inpatient Hospital Copayment
Outpatient Substance Abuse Detoxification Therapy	The greater of one-half (1/2) the Specialty Physician's Copayment or \$5 per session
Authorized Residential Treatment Facility Services for Children and Adolescents	Same as Other Participating Health Care Facilities
Nutritional Evaluation 3 visit maximum per Member per Contract Year	Same as Physician's Office Visit Copayment
Transplant Travel Services Maximum \$10,000 maximum benefit	
Short-term Rehabilitative Therapy Services , Cardiac Rehabilitation Services and Chiropractic Care Services* Services provided on an outpatient basis are limited to a 20 day maximum per Member per Contract Year	\$35 Copayment per office visit
Wigs for Cancer Patients \$350 maximum per Member per Contract Year	No Charge



Schedule of Copayments

Total Copayment Maximum **	
Individual Member Total Copayment Maximum	\$1,000 per Contract Year
Membership Unit Total Copayment Maximum	\$2,000 per Contract Year

* Physical, occupational, and other Short-term rehabilitation services provided in the home only count towards home health care maximums if the services are given in accordance with an approved treatment plan and commencing within seven days of a hospital stay and provided by a home health care agency.

If the above provision is not met, physical, occupational, and other Short-term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services and benefit limitation in the Schedule of Copayments, but are subject to the benefit limitations described under "Short-term Rehabilitative Therapy" in the Schedule of Copayments.

**Only Copayments identified in this Schedule of Copayments which have been paid by a Member for Inpatient Hospital Services, Outpatient Facility Services, Inpatient Services at Other Participating Health Care Facilities, Advanced Radiological Imaging (MRI, MRA, PET, CAT scans), Inpatient Mental Health Services, Inpatient Substance Abuse Rehabilitation and Inpatient Detoxification Services apply to these maximums.

*** Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized and will not count toward any plan limits that are shown in the Schedule for mental health and substance abuse services including in-hospital services. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined by the Healthplan Medical Director in accordance with the applicable mixed services claim guidelines.



ERISA REQUIRED INFORMATION

The name of the Plan is: Valassis Communications, Inc.

The name, address, ZIP code and business telephone number of the sponsor of the Plan is: Valassis Communications, Inc.
One Targeting Centre
Windsor, CT 06095
860-285-6194

Employer Identification Number (EIN): 382760940

Plan Number: 501

The name, address, ZIP code and business telephone number of the Plan administrator is: Valassis Communications, Inc.
One Targeting Centre
Windsor, CT 06095
860-285-6194

The name, address and ZIP code of the person designated as agent for the service of legal process is: Todd Wiseley
19775 Victor Parkway
Livonia, MI 48152
734-591-7386

The office designated to consider the appeal of denied claims is: CIGNA HealthCare of Connecticut, Inc.
National Appeals Unit (NAU)
P.O. Box 5225
Scranton, PA 18505-5225
Healthplan Toll Free Number on your CIGNA HealthCare ID Card

The cost of the Plan is: EMPLOYEE CONTRIBUTES FOR DEPENDENTS

The Plan's fiscal year ends on: 12/31

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.



ERISA Summary Plan Description

Plan Trustees

A list of any Trustees of the Plan, which includes name, title and address, is available upon request from the Plan Administrator.

Plan Type

The Plan is a healthcare benefit plan.

Collective Bargaining Agreement

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

Discretionary Authority

The Plan Administrator delegates to the Healthplan the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to the Healthplan the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of Employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. The procedure by which benefits may be changed or terminated, by which the eligibility of classes of Employees may be changed or terminated, or by which part or all of the Plan may be terminated, is contained in the Employer's Plan Document, which is available for inspection and copying from the Plan Administrator designated by the Employer. No consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered medical expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) due to your or your Dependent's total disability which began prior to and has continued beyond the date the policy(s) terminates will not be affected by the Plan termination. Rights to purchase limited amounts of life and medical insurance to replace part of the benefits lost because the policy(s) terminated may arise under the terms of the policy(s). A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the date you leave Active Service;
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute, or;
- the date the policy(s) terminates.

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this policy(s). No extension of benefits or rights will be available solely because the Plan terminates.

Statement of Rights

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrators office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at



ERISA Summary Plan Description

the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- obtain, upon written request to the Plan Administrator, copies of documents governing the plan, including insurance contracts and collective-bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your federal continuation coverage rights.
- reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the Employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the

interest of you and other plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or federal court.

Enforce Your Rights

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

CLAIM DETERMINATION PROCEDURES UNDER ERISA

The following complies with federal law effective July 1, 2002. Provisions of the laws of your state may supersede.

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be medically necessary to be covered under the plan.



The procedures for determining medical necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical necessity determinations are made on either a preservice, concurrent, or postservice basis, as described below:

Certain services require prior authorization in order to be covered. This prior authorization is called a "preservice medical necessity determination." The Agreement describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care provider) must request medical necessity determinations according to the procedures described below, in the Agreement, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not medically necessary, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Agreement, in your provider's network participation documents, and in the determination notices.

Preservice Medical Necessity Determinations

When you or your representative request a required medical necessity determination prior to care, the Healthplan shall notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond the Healthplan's control, the Healthplan will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to the Healthplan within 45 days after receiving the notice. The determination period will be suspended on the date the Healthplan sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

If the determination periods above would (a) seriously jeopardize your life or health, your ability to regain maximum function, or (b) in the opinion of

a Physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, the Healthplan will make the preservice determination on an expedited basis. The Healthplan Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. The Healthplan will notify you or your representative of an expedited determination within 72 hours after receiving the request. However, if necessary information is missing from the request, the Healthplan will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to the Healthplan within 48 hours after receiving the notice. The Healthplan will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If you or your representative fails to follow the Healthplan's procedures for requesting a required preservice medical necessity determination, the Healthplan will notify you or your representative of the failure and describe the proper procedures for filing within five days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless you or your representative requests written notification.

Concurrent Medical Necessity Determinations

When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent medical necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, the Healthplan will notify you or your representative of the determination within 24 hours after receiving the request.

Postservice Medical Necessity Determinations

When you or your representative requests a medical necessity determination after services have been rendered, the Healthplan will notify you or your representative of the determination within 30 days



ERISA Summary Plan Description

after receiving the request. However, if more time is needed to make a determination due to matters beyond the Healthplan's control the Healthplan will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to the Healthplan within 45 days after receiving the notice. The determination period will be Suspended on the date the Healthplan sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Postservice Claim Determinations

When you or your representative requests payment for services which have been rendered, the Healthplan will notify you or your representative of the claim payment determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond the Healthplan's control the Healthplan will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to the Healthplan within 45 days after receiving the notice. The determination period will be suspended on the date the Healthplan sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a description of any additional material

or information necessary to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; (5) 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 adverse determination regarding your claim, and 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; (6) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

Assistance with Your Questions.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. The Healthplan will provide administrative services of the following nature: Claim Administration; Cost Containment; Financial; Banking and Billing Administration. Benefits provided under this Agreement are fully guaranteed by the Healthplan. This Agreement is issued by the Healthplan.



CIGNA HealthCare 24-Hour Health Information LineSM 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 LineSM and get the information you need. Quickly and easily.



Health Information Library

1.800.564.8982

Aging

- 3000 A Healthy Life Style for Older Adults
- 3001 Abuse of Older Adults
- 3002 Adult Day Care Programs
- 3003 Advance Directives
- 3004 Alcohol and Aging
- 3005 Alzheimer's Disease
- 3006 Caregiver's Guide
- 3007 Constipation
- 3008 Dementia
- 3009 Dental Care for Older Adults
- 3010 Depression in Older Adults
- 3011 Elderhostel and Adult Education
- 3012 Erectile Dysfunction (Impotence)
- 3013 Exercise for Older Adults
- 3014 Fluid Requirements of Older Adult
- 3015 Health Benefits for Veterans
- 3016 Health Changes With Aging
- 3017 Home Healthcare
- 3018 Housing Options for Seniors
- 3019 How to Choose a Nursing Home
- 3020 Hypothermia in Older Adults
- 3021 Insomnia in Older Adults
- 3022 Loneliness in Older Adults
- 3023 Long-Term Care Insurance
- 3024 Medicaid
- 3025 Medicare: Health Insurance
- 3026 Medicines: Problems They Can Cause
- 3027 Nutrition for the Later Years
- 3028 Pets Benefit the Older Adult
- 3029 Retirement Planning
- 3030 Preventing a Broken Hip
- 3031 Medicines: Using Them Safely
- 3032 Self-Esteem in Older Adults
- 3033 Senior Centers
- 3034 Sexuality in the Later Years
- 3035 Skin Care and Protection
- 3036 Social Security and SSI
- 3037 Stress in Later Years
- 3038 Stroke
- 3039 Talking With Your Healthcare Provider

Allergies

- 3100 Allergies

- 3101 Allergies: National Support Services
- 3102 Allergy Proof Your Home
- 3103 Allergy Testing
- 3104 Allergy Treatment
- 3106 Contact Dermatitis
- 3107 Drug Allergy
- 3108 Eczema
- 3109 Food Allergy
- 3110 Hay Fever (Seasonal Allergic Rhinitis)
- 3111 Hives
- 3105 Insect Bites and Stings
- 3112 Poison Ivy, Sumac, and Oak
- 3113 Severe Allergic Reaction

Behavioral Health

- 3300 Abuse and Neglect--Children
- 3301 Abuse and Violence - Adults
- 3302 Aggressive Behavior in Children
- 3303 Agoraphobia
- 3304 Alcohol Dependence (Alcoholism)
- 3305 Alcoholism: Information and Resources
- 3306 Amnesia
- 3307 Anger Management
- 3308 Anorexia Nervosa
- 3309 Antisocial Personality Disorder
- 3311 Attention-Deficit/Hyperactivity Disorder (ADHD) in Adults
- 3312 Attention-Deficit/Hyperactivity Disorder (ADHD)
- 3313 Binge Eating Disorder (Compulsive Overeating)
- 3314 Bipolar Disorder (Manic-Depressive Illness)
- 3315 Bulimia Nervosa
- 3316 Club Drugs
- 3317 Cocaine Use
- 3318 Compulsive Gambling
- 3319 Confusion
- 3320 Delirium
- 3321 Depression
- 3322 Drug Abuse Among Teenagers
- 3323 Drug Abuse and Addiction
- 3324 Drug Abuse Resources
- 3325 Drugs in the Workplace
- 3326 Emotional Abuse - Effects on Children

- 3327 Exhibitionism
- 3328 Fetishism
- 3329 Gender Identity Disorder
- 3330 Grief and Loss
- 3331 Hallucinations
- 3332 Hazards of Smoking
- 3333 Hypnosis
- 3334 Hypochondria (Hypochondriasis Disorder)
- 3335 Incest
- 3336 Kleptomania
- 3337 Letting Go of Resentment
- 3338 Lying: Pathologic
- 3339 Masochism
- 3340 Mental Health Professionals
- 3341 Multiple Personality (Dissociative Identity Disorder)
- 3342 Narcissism (Narcissistic Personality Disorder)
- 3343 Nervous Breakdown
- 3344 Nightmares and Sleep Terrors
- 3345 Obsessive-Compulsive Disorder (OCD)
- 3346 Panic Attacks (Panic Disorder)
- 3347 Paranoid Personality Disorder
- 3348 Pedophilia
- 3349 Phobias
- 3350 Post-Traumatic Stress Disorder
- 3351 Prescription Drug Abuse
- 3352 Psychosis
- 3353 Psychosomatic Illness (Somatization Disorder)
- 3354 Pyromania
- 3355 Sadism
- 3356 Schizophrenia
- 3357 Seasonal Affective Disorder (SAD)
- 3358 Self-Esteem
- 3359 Sex Therapy
- 3360 Sexual Abuse and Children
- 3361 Smokeless Tobacco
- 3362 Smoking: Ways to Quit
- 3363 Suicide
- 3364 Teenage Drinking
- 3365 Transvestism
- 3366 Twelve Step Programs
- 3367 Types of Therapy for Mental Health
- 3368 Voyeurism

Bones, Joints and Muscles

- 3150 Achilles Tendon Injury
- 3151 Amputation
- 3152 Ankle Sprain
- 3153 Anterior Cruciate Ligament (ACL) Injury
- 3154 Arthritis
- 3155 Arthritis: Chores Made Easier
- 3156 Arthroscopic Meniscectomy
- 3157 Arthroscopy
- 3158 Artificial Limb
- 3159 Aspirin and Arthritis
- 3160 Athlete's Foot
- 3161 Back Pain Prevention: Body Mechanics
- 3162 Bone Infection (Osteomyelitis)
- 3163 Bowlegs and Knock-Knees
- 3164 Broken Ankle
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4006	Cirrhosis
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4008	Constipation
4009	Crohn's Disease
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4015	Gallbladder Removal (Cholecystectomy)
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4028	Ileostomy and Colostomy
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4030	Intestinal Gas (Flatulence)
4031	Irritable Bowel Syndrome (Spastic Colon)
4032	Laparoscopic Cholecystectomy
4033	Laxative Abuse
4034	Pilonidal Disease
4035	Rectal Bleeding
4036	Rectal Itching
4037	Stomach Flu (Viral Gastroenteritis)
4038	Traveler's Diarrhea
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3955	Laryngitis
3956	Nosebleed (Epistaxis)
3957	Ruptured Eardrum
3958	Sinusitis
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- 4810 Emphysema
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- 4812 Pulmonary Embolism
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- 4869 Skin Lesions
- 4870 Skin or Soft Tissue Abscess
- 4871 Sunburn
- 4872 Tanning Beds
- 4873 Warts

Surgery

- 5000 Anesthesia
- 5001 Body Contouring
- 5002 Breast Enlargement (Augmentation Mammoplasty)
- 5003 Breast Reconstruction
- 5004 Breast Reduction (Reduction Mammoplasty)
- 5005 Eyelid Surgery (Blepharoplasty)
- 5006 Facelifts
- 5007 Laser Treatment
- 5008 Liposuction
- 5009 Nose Reconstruction (Rhinoplasty)
- 5010 Skin Resurfacing
- 5011 Tummy Tuck

Symptoms

- 5050 Abdominal Cramps
- 5051 Constipation
- 5052 Cough
- 5053 Dehydration
- 5054 Dizziness and Vertigo
- 5055 Earache
- 5057 Fever
- 5058 Heart Palpitations

- 5059 Heartburn
- 5060 Insomnia
- 5061 Irritability
- 5062 Loss of Appetite
- 5063 Lymph Nodes: Enlarged
- 5064 Memory Loss
- 5065 Nausea and Vomiting
- 5066 Nervousness
- 5067 Personality Change
- 5068 Rectal Bleeding
- 5069 Shortness of Breath
- 5070 Skin Lesions
- 5071 Swallowing Difficulty (Dysphagia)
- 5072 Tinnitus
- 5073 Urinary Incontinence
- 5074 Urination Problems
- 5075 Wheezing

Tests and Examinations

- 5100 Angiograms
- 5101 Arterial Blood Gases
- 5102 Barium Enema
- 5103 Barium X-Ray Exam: Esophagus and Stomach
- 5104 Biopsy
- 5105 Blood (Serum) Glucose Test
- 5106 Blood: Iron Test
- 5107 Bone Marrow Biopsy
- 5108 Bone Scan
- 5109 Bronchoscopy
- 5110 Cholesterol: Lipid Panel Test
- 5111 Colonoscopy
- 5112 Colorectal Cancer Screening
- 5113 Colposcopy of the Vagina and Cervix
- 5114 Complete Blood Count Test (CBC)
- 5115 Coronary Angiogram
- 5116 CT Scanning
- 5117 Cystoscopy
- 5118 Diagnostic Laparoscopy
- 5119 Echocardiogram
- 5120 Electrocardiogram (ECG or EKG)
- 5121 Electroencephalogram (EEG)
- 5122 Electromyogram (EMG)
- 5123 Endoscopic Retrograde Cholangiopancreatography (ERCP)
- 5124 Fluoroscopy
- 5125 Heart Catheterization
- 5126 Holter Monitors
- 5127 Magnetic Resonance Imaging (MRI)
- 5128 Mammograms
- 5129 Pap Smear (Cervical Smear)

- 5130 Percutaneous Transhepatic Cholangiography (PTHC)
- 5131 Sigmoidoscopy
- 5132 Thyroid Scan
- 5133 Thyroid-Stimulating Hormone (TSH) Test
- 5134 Thyroxine (T4) Test
- 5135 Ultrasound Scanning
- 5136 Urine Culture
- 5137 Urine Tests
- 5138 X-Rays

Urinary and Genital Systems

- 5350 Acute Kidney Failure (Acute Renal Insufficiency)
- 5351 Bladder Infection (Cystitis)
- 5352 Blood in Urine (Hematuria)
- 5353 Chronic Kidney Failure (Chronic Renal Insufficiency)
- 5354 Functional Urinary Incontinence
- 5355 Indwelling Catheter Care
- 5356 Kegel Exercises for Bladder Control
- 5357 Kidney Infection (Pyelonephritis)
- 5358 Kidney Stones
- 5359 Lithotripsy for Kidney Stones
- 5360 Overflow Incontinence
- 5361 Urge Incontinence
- 5362 Urinary Catheterization
- 5363 Urinary Incontinence
- 5364 Urinary Obstruction
- 5365 Urinary Tract Infection in Men
- 5366 Urinary Tract Infection in Women

Women's Health

- 5200 Abdominal Hysterectomy
- 5201 Abuse and Violence - Adults
- 5202 Amniocentesis
- 5203 Atrophic Vaginitis
- 5204 Bartholin's Gland Cyst
- 5205 Benign Ovarian Tumor
- 5206 Birth Control
- 5207 Birth Control Patch
- 5208 Birth Control Pills
- 5209 Bleeding Between Menstrual Periods (Metrorrhagia)
- 5210 Breast Infection (Mastitis)
- 5211 Breast Self-Exam
- 5212 Cervical Cap
- 5213 Cervical Dysplasia
- 5214 Cervical Polyps
- 5215 Cervicitis
- 5216 Cesarean Section

- 5217 Choosing a Healthcare Provider for Your Pregnancy
- 5218 Chorionic Villus Sampling (CVS)
- 5219 D&C, Diagnostic (Dilation and Curettage)
- 5220 D&C, Therapeutic (Dilation and Curettage)
- 5221 Danger Signs in Pregnancy
- 5222 Depo-Provera
- 5223 Diabetes in Pregnancy
- 5224 Diaphragm
- 5225 Diet During Pregnancy
- 5226 Diethylstilbestrol (DES)
- 5227 Drug, Alcohol, and Tobacco Use During Pregnancy
- 5228 Ectopic Pregnancy
- 5229 Emergency Birth Control (Morning-After Pill)
- 5230 Endometrial Biopsy
- 5231 Endometriosis
- 5232 Episiotomy
- 5233 Exercise After Delivery
- 5234 Exercise During Pregnancy
- 5235 Female Condom
- 5236 Female Sterilization
- 5237 Feminine Hygiene
- 5238 Fetal Alcohol Syndrome
- 5239 Fibrocystic Breast Changes
- 5240 Genetic Screening Before or During Pregnancy
- 5241 Getting Ready for Pregnancy
- 5242 Hair Loss in Women
- 5243 Hot Flashes
- 5244 Hysteroscopy
- 5245 Infertility
- 5246 Intrauterine Device (IUD)
- 5247 Labor and Delivery
- 5248 Mammograms
- 5249 Menopausal Hormone Therapy
- 5250 Menopause
- 5251 Menstrual Cramps
- 5252 Miscarriage
- 5253 Missed Menstrual Periods (Amenorrhea)
- 5254 Morning Sickness
- 5255 Natural Family Planning
- 5256 Nipple Discharge (Galactorrhea)
- 5257 Normal Growth of a Baby During Pregnancy
- 5258 Norplant
- 5259 Ovarian Cysts
- 5260 Overcoming Fear of Childbirth
- 5261 Ovulation Abnormalities
- 5262 Painful Intercourse
- 5263 Pelvic Examination
- 5264 Pelvic Inflammatory Disease
- 5265 Pelvic Support Problems



- 5266 Postmenopausal Bleeding
- 5267 Postpartum Care
- 5268 Postpartum Complications
- 5269 Postpartum Depression
- 5270 Preeclampsia
- 5271 Pregnancy Tests
- 5272 Premenstrual Dysphoric Disorder (PMDD)
- 5273 Premenstrual Syndrome (PMS)
- 5274 Prenatal Care
- 5275 Prenatal Tests
- 5276 Routine Healthcare for Women
- 5277 Ruptured Membranes
- 5278 Sex During Pregnancy
- 5279 Sexual Abstinence
- 5280 Sexual Response in Women
- 5281 Skin Conditions During Pregnancy
- 5282 Smoking During Pregnancy
- 5283 Spermicides
- 5284 Stress Incontinence in Women
- 5285 Tipped Uterus
- 5286 Toxic Shock Syndrome
- 5287 Travel When You Are Pregnant
- 5288 Uterine Fibroids
- 5289 Vaginal Contraceptive Ring
- 5290 Vaginal Cysts, Polyps, and Warts
- 5291 Vaginal Hysterectomy
- 5292 Vaginal Hysterectomy with Laparoscopy
- 5293 Vaginitis
- 5294 Vulvar Dystrophy
- 5295 Vulvitis
- 5296 Working During Pregnancy
- 5297 Yeast Infection (Candidiasis)