

Summary of Coverage

Employer: City of Anaheim
Group Policy: GP-476571
SOC: 1A
Issue Date: December 19, 2008
Effective Date: January 1, 2009

The benefits shown in this Summary of Coverage are available for you and your eligible dependents.

This Summary of Coverage may be an electronic version of the Summary of Coverage on file with your Employer and Aetna Life Insurance Company. In case of any discrepancy between an electronic version and the printed copy which is part of the group insurance contract issued by Aetna Life Insurance Company, or in case of any legal action, the terms set forth in such group insurance contract will prevail. To obtain a printed copy of this Summary of Coverage, please contact your Employer.

Eligibility

Employees

You are in an Eligible Class if you are a full-time employee of the City of Anaheim and considered eligible to receive benefits in accordance with the eligibility criteria of your specific workgroup. Aetna will rely upon the Employer's certification as to a person's eligibility for coverage under the Plan and as to any fact concerning such eligibility.

Your Eligibility Date, if you are then in an Eligible Class, is the Effective Date of this Plan. Otherwise, it is the first day of the calendar month coinciding with or next following one completed month of employment with the City, but not before the later of the Effective Date of this Plan and the date you enter the Eligible Class.

Dependents

You may cover your:

- wife or husband; and
- unmarried children who are under 19 years of age.

Any other unmarried child under age 25 who goes to school on a regular basis and depends solely on you for support will be covered as a dependent.

Your children include:

- Your biological children.
- Your adopted children.
- Your stepchildren.
- Any other child you support who either lives with you in a parent-child relationship or whose parent is your child and is covered as a dependent under this Plan.

OAMC Actives and Non-Medicare Retirees

You may also cover as your dependent a person who is your domestic partner if you and your partner:

- meet the requirements under California law for entering into a domestic partnership; and
- have jointly executed and filed a Declaration of Domestic Partnership with the Secretary of State; or
- have completed and signed a "Declaration of Domestic Partnership" which is acceptable to your Employer.

No person may be covered both as an employee and dependent and no person may be covered as a dependent of more than one employee.

Enrollment Procedure

Initial Enrollment

To become covered under this Plan, you must request enrollment during the Initial Enrollment Period for yourself and any eligible dependents you wish to cover. The Initial Enrollment Period starts on your Eligibility Date and ends 31 days later.

You will be required to enroll in a manner determined by Aetna and your Employer. This will allow your Employer to deduct your contributions from your pay. Be sure to enroll before the end of the Initial Enrollment Period. Otherwise, you may be considered a **Late Enrollee**.

Your contributions toward the cost of this coverage will be deducted from your pay and are subject to change. The rate of any required contributions will be determined by your Employer. See your Employer for details.

Late Enrollment

If you do not sign and return your enrollment form during the Initial Enrollment Period, you and your eligible dependents may be considered **Late Enrollees** and coverage may be deferred until the next late entrant enrollment period. If at the time of your initial enrollment, you elect coverage for yourself only and later request coverage for your eligible dependents, they may be considered **Late Enrollees**.

You must sign and return your enrollment form before the end of the next late entrant enrollment period.

However, you and your eligible dependents may not be considered **Late Enrollees** under the circumstances described in the "Special Enrollment Periods" section below.

Special Enrollment Periods

A person, including yourself, will not be considered to be a **Late Enrollee** if all of the following are met:

- You did not elect Health Expense Coverage for yourself or any eligible dependent during the Initial Enrollment Period (or during a subsequent late enrollment period) because at that time:
 - i. the person was covered under another group health plan or other health insurance coverage; and
 - ii. you stated, in writing, at the time you refused coverage that the reason for the refusal was because the person had such coverage, but such written statement is required only if your Employer requires the statement and gives you notice of the requirement; and

the person loses such coverage because:

- i. it was provided under a COBRA continuation provision, and coverage under that provision was exhausted; or
- ii. it was not provided under a COBRA continuation provision, and either the coverage was terminated as a result of loss of eligibility for the coverage, including loss of eligibility as a result of:
 - legal separation or divorce;
 - death;
 - termination of employment;
 - reduction in the number of hours of employment;
 - the employer's decision to stop offering the group health plan to the Eligible Class to which the employee belongs;
 - cessation of a dependent's status as an eligible dependent as such is defined under this Plan;
 - the operation of another Plan's lifetime maximum on all benefits, if applicable;

- such coverage was under the Healthy Families Program and such coverage terminates due to exceeding the program's income or age limits;
 - such coverage was no share-of-cost Medi-Cal coverage and such coverage terminated; or
- iii. employer contributions toward the coverage were terminated.
- You elect coverage within 31 days of the date the person loses coverage for one of the above reasons.

In addition, you and any eligible dependents will not be considered to be **Late Enrollees** if your Employer offers multiple health benefit plans and you elect a different plan during the open enrollment period.

Also, the following persons will not be considered to be **Late Enrollees** given any of the following circumstances:

- You, if you are eligible, but not enrolled, and your newly acquired dependents through marriage, birth, adoption, or placement for adoption. However, you must request enrollment for your newly acquired dependent(s) and yourself, if you are not already enrolled, within 31 days of the marriage, birth, adoption, or placement for adoption.
- Your spouse or domestic partner from whom you are separated or divorced, or child who would meet the definition of a dependent, if you are subject to a court order requiring you to provide health expense coverage for such spouse or child. However, you must request enrollment within 31 days of the court order.

Coverage will be effective:

- i. in the case of marriage, on the date the completed request for enrollment is received;
- ii. in the case of a newborn, on the date of birth;
- iii. in the case of adoption, on the date of the child's adoption or placement for adoption;
- iv. in the case of court ordered coverage of a spouse, domestic partner or child, on the date of the court order;
- v. in the case of loss of coverage under COBRA continuation, on the date COBRA continuation ended; and
- vi. in the case of loss of coverage for other reasons, the date on which the applicable event occurred.

Effective Date of Coverage

Employees

Your coverage will take effect on the later to occur of:

- your Eligibility Date; and
- the date you return your signed enrollment form.

If you are considered a **Late Enrollee**, coverage will take effect on the first day of the second calendar month following the end of the late entrant enrollment period during which you elect coverage.

Dependents

Coverage for your dependents will take effect on the date yours takes effect if, by then, you have enrolled for dependent coverage.

You should report any newly acquired dependents. This may affect your contributions. Coverage will take effect as described in the section entitled, "Special Enrollment Periods".

If any dependent is considered a **Late Enrollee**, coverage will take effect on the first day of the second calendar month following the end of the late entrant enrollment period during which you elect coverage for such dependent.

Retired Employees

In lieu of corresponding rules which apply to employees:

- If any Health Expense Benefits are payable based on a "period of disability", the rule which applies to determine when a dependent's period of disability ends will also apply to you.
- The rule which applies to a dependent to determine if total disability exists when Health Expense Coverage terminates will also apply to you.

Special Rules Which Apply to an Adopted Child

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- such placement takes effect after the date your coverage becomes effective; and
- you make written request for coverage for the child within 31 days of the date the child is placed with you for adoption.

Coverage for the child will become effective on the date the child is placed with you for adoption. If request is not made within such 31 days, coverage for the child will be subject to all of the terms of this Plan.

Special Rules Which Apply to a Child Who Must Be Covered Due to a Qualified Medical Child Support Order

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent and for whom you are required to provide health coverage as the result of a qualified medical child support order issued on or after the date your coverage becomes effective. You must make written request for such coverage. Coverage for the child will become effective on the date specified by your Employer.

If you are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

Health Expense Coverage

Employees and Dependents

Your Booklet-Certificate spells out the period to which each maximum applies. These benefits apply separately to each covered person. Read the coverage section in your Booklet-Certificate for a complete description of the benefits payable.

If a hospital or other health care facility does not separately identify the specific amounts of its room and board charges and its other charges, Aetna will use the following allocations of these charges for the purposes of the group contract:

| | |
|-------------------------|-----|
| Room and board charges: | 40% |
| Other charges: | 60% |

This allocation may be changed at any time if Aetna finds that such action is warranted by reason of a change in factors used in the allocation.

Health Expense Coverage under this Plan is payable as described under **Basic Health Expense Coverage**. Benefits may also be payable under **Special Comprehensive Medical Expense Coverage**. Read both coverage sections to determine the benefits available.

Basic Health Expense Coverage

Vision Care Benefits

| | |
|--------------------|------|
| Payment Percentage | 100% |
|--------------------|------|

Prescription Drug Expense Coverage

Prescription Drug Benefits

Prescription Drug Expenses accumulate toward the Special Comprehensive Medical Expense Coverage Lifetime Maximum.

Payment Percentage

100% after the Calendar Year Deductible as to:

| Preferred Pharmacy | Copay per Prescription or Refill | |
|-----------------------------|----------------------------------|---|
| | Supply of up to 30 days | Mail Order Drug Supply of over 30 days* |
| Generic Drugs | \$ 10 | \$ 20 |
| Brand Name Drugs | | |
| On Medication Formulary | \$ 25 | \$ 50 |
| Not on Medication Formulary | \$ 30 | \$ 60 |

* but no more than a 90 day maximum supply.

A Separate Brand Name Fee may apply to a prescription for a brand name drug. See your Booklet-Certificate for details.

Performance Enhancement Maximum 4 unit doses per 30 day supply

The following expenses for Preferred Care:
 Home Health Care Expenses
 Short Term Rehabilitation Expenses
 Outpatient Behavioral Health and Chemical Dependency Expenses

Preferred Family Deductible Limit \$ 500
 Non- Preferred Family Deductible Limit \$ 500

Emergency Room Copay \$ 75 per visit

This Emergency Room Copay applies to Hospital Expenses incurred for emergency and non-emergency care provided by a Preferred or Non-Preferred Care Provider. This amount is waived if the person becomes confined in a hospital.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

The Benefits Payable

After any applicable deductible or copay amount, the Health Expense Benefits paid under this Plan in a calendar year are paid at the Payment Percentage which applies to the type of Covered Medical Expense which is incurred, except for any different benefit level which may be provided later in this Booklet-Certificate.

If any expense is covered under one type of Covered Medical expense, it cannot be covered under any other type.

Payment Percentage

The Payment Percentage applies after any deductible or copay amounts.

| | Preferred Care | Non-Preferred Care |
|----------------------------------|---------------------------|-------------------------------|
| <i>Hospital Expenses</i> | | |
| Emergency Room Treatment | | |
| Emergency and Non-Emergency Care | 90% after a \$75 copay | 90% after a \$75 copay |
| Other Hospital Expenses | 90% after deductible | 60% after deductible |

Physician Fees

| | | |
|--|--------------------------|-----------------------|
| Office Care | 100% after a \$ 20 copay | 60% deductible waived |
| Routine Physical Exam Expenses | 100% after a \$ 20 copay | 60% deductible waived |
| Routine Eye Exam Expenses | 100% deductible waived | 60% deductible waived |
| Routine Hearing Exam Expenses | 100% after a \$ 20 copay | 60% after deductible |
| Other Physician Services | 90% after a \$20 copay | 60% after deductible |
| Hearing Aid Expense Benefit | 100% after deductible | 100% after deductible |
| Mammogram | 90% deductible waived | 60% deductible waived |
| Pap smear | 100% after a \$ 20 copay | 60% deductible waived |
| Prostate specific antigen (PSA) test; | 100% after a \$ 20 copay | 60% deductible waived |
| Fecal occult blood test; or | 100% after a \$ 20 copay | 60% deductible waived |
| Any other routine cancer screening test recommended by the American Cancer Society | 100% after a \$ 20 copay | 60% deductible waived |

Short Term Rehabilitation Expenses

| | | |
|--------------------|-------------------------------------|-----------------------|
| Payment Percentage | 100 % after a \$ 20 Per Visit Copay | 60 % after deductible |
|--------------------|-------------------------------------|-----------------------|

For Short-Term Rehabilitation Speech Therapy Expenses

| | | |
|--------------------|-----------------------------------|----------------------|
| Payment Percentage | 100% after a \$20 Per Visit Copay | 60% after deductible |
|--------------------|-----------------------------------|----------------------|

For Diagnostic Laboratory and X-Ray Services (performed in physician's office)

| | | |
|--------------------|-----------------------|-----------------------|
| Payment Percentage | 100% after \$20 copay | 60% deductible waived |
|--------------------|-----------------------|-----------------------|

For Diagnostic Laboratory and X-Ray Services(performed in freestanding facility)

| | | |
|--------------------|-----------------------|-----------------------|
| Payment Percentage | 100% after \$20 copay | 60% deductible waived |
|--------------------|-----------------------|-----------------------|

Other Covered Medical Expenses

| | | |
|--|-----------------------------------|-----------------------|
| Convalescent Facility Expenses (Freestanding Facility) | 90% after deductible | 80% after deductible |
| Convalescent Facility Expenses (Hospital) | 90% after deductible | 60% after deductible |
| Home Health Care Expenses | 100% after a \$20 per visit copay | 60% after deductible |
| Skilled Nursing Care Expenses | 90% after deductible | 80% after deductible |
| Hospice Care Expenses | | |
| Inpatient Care | 100% after deductible | 100% after deductible |
| Outpatient Care | 100% after deductible | 100% after deductible |
| Acupuncture | 100% after a \$20 per visit copay | Not Covered |
| Spinal Disorder Treatment | 100% after a \$20 per visit copay | Not Covered |
| All Other Covered Medical Expenses for which a Payment Percentage is not otherwise shown | 90% after a \$20 copay | 60% after deductible |

National Medical Excellence
 Travel and Lodging Expenses 100%

Payment Percentage and Special Maximums for Alcoholism, Drug Abuse and Mental Disorders

| | Preferred Care | Non-Preferred Care |
|---|--|-------------------------------|
| <i>Alcoholism, Drug Abuse and Mental Disorders</i> | | |
| Inpatient Treatment | 90% after deductible | 60% after deductible |
| Outpatient Treatment | 100% after \$20 per visit copay. Deductible waived. | 60% after deductible |
| Special Alcoholism and Drug Abuse Inpatient Calendar Year Maximum Days | 30 | |
| Detoxification | Unlimited | |
| Special Alcoholism and Drug Abuse Outpatient Calendar Year Maximum Visits | 20 | |
| Detoxification | Unlimited | |

Payment Limits

These limits apply to Covered Medical Expenses except:

Expenses applied against any deductible.

Payment Limits which Apply to Expenses for a Person

When a person's Covered Medical Expenses for Preferred Care, for which no benefits are paid because of the Payment Percentage, Calendar Year Deductible, copay, and penalty amounts, reach \$2,000 in a calendar year, benefits will be payable at 100% for all of his or her Covered Medical Expenses, to which this limit applies and which are incurred for Preferred Care in the rest of that calendar year.

Payment Limits which Apply to Expenses for a Family

When a family's Covered Medical Expenses for Preferred Care, for which no benefits are paid because of the Payment Percentage, Calendar Year Deductible, copay and penalty amounts, reach \$ 4,000 in a calendar year, benefits will be payable at 100% for all their Covered Medical Expenses, to which this limit applies and which are incurred for Preferred Care in the rest of that calendar year.

Benefit Maximums

(Read the coverage section in your Booklet Certificate for a complete description of the benefits available.)

| | |
|---|-------------------------------------|
| Convalescent Days | 100 per calendar year |
| Private Duty Nursing Care Maximum Shifts | 70 per calendar year |
| Acupuncture Visit Maximum | 12 per calendar year |
| Spinal Disorder Maximum Visits | 20 per calendar year |
| Routine Hearing Exam Maximum | 1 exam per 12 months |
| Hearing Aid Expense Benefit Maximum | \$1,000 every 36 months |
| Vision Care Supply Maximum | \$200 per 12 months |
| National Medical Excellence Lodging Expenses Maximum | \$ 50 per day |
| Travel and Lodging Maximum | \$ 10,000 per occurrence |
| Private Room Limit | The institution's semiprivate rate. |
| Lifetime Maximum Benefit | \$ 6,000,000 |
| Restoration Amount | \$ 10,000 |

Pregnancy Coverage

Benefits are payable for pregnancy-related expenses of female employees and dependents on the same basis as for a disease.

In the event of an inpatient confinement:

- Such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours following a vaginal delivery; and a minimum of 96 hours following a cesarean delivery. If, after consultation with the attending physician, a person is discharged earlier, benefits will be payable for 2 post-delivery home visits by a health care provider.
- Certification of the first 48 hours of such confinement following a vaginal delivery or the first 96 hours of such confinement following a cesarean delivery is not required. Any day of confinement in excess of such limits must be certified. You, your physician, or other health care provider may obtain such certification by calling the number shown on your ID Card.

Normally, the expenses must be incurred while the person is covered under this Plan. If expenses are incurred after the coverage ceases, they will be considered for benefits only if satisfactory evidence is furnished to Aetna that the person has been totally disabled since her coverage terminated.

Elective abortions: Coverage is limited to abortions performed because the life of the mother would be in danger if the fetus were carried to term and those which result in medical complications.

Prior Plans: Any pregnancy benefits payable by previous group medical coverage will be subtracted from medical benefits payable for the same expenses under this Plan.

Sterilization Coverage

Health Expense Coverage: Benefits are payable for charges made in connection with any procedure performed for sterilization of a person, including voluntary sterilization, on the same basis as for a disease.

Adjustment Rule

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the group contract, except that an increase is subject to any Active Work Rule described in Effective Date of Coverage section of this Summary of Coverage.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

General

This Summary of Coverage replaces any Summary of Coverage previously in effect under the group contract. Requests for amounts of coverage other than those to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

The insurance described in this Booklet-Certificate will be provided under Aetna Life Insurance Company policy form GR-29.

**KEEP THIS SUMMARY OF COVERAGE
WITH YOUR BOOKLET-CERTIFICATE**

**THE BENEFITS OF THE POLICY PROVIDING YOUR
COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF
A STATE OTHER THAN FLORIDA**

Additional Information Provided by Aetna Life Insurance Company

Inquiry Procedure

The plan of benefits described in the Booklet-Certificate is underwritten by:

**Aetna Life Insurance Company (Aetna)
151 Farmington Avenue
Hartford, Connecticut 06156**

Telephone: (860) 273-0123

If you have questions about benefits or coverage under this plan, call Member Services at the number shown on your Identification Card. You may also call Aetna at the number shown above.

If you have a problem that you have been unable to resolve to your satisfaction after contacting Aetna, you should contact the Consumer Service Division of the Department of Insurance at:

300 South Spring Street
Los Angeles, CA 90013

Telephone: 1-800-927-4357 or 213-897-8921

You should contact the Bureau only after contacting Aetna at the numbers or address shown above.

Participating Providers

We want you to know more about the relationship between Aetna Life Insurance Company and its affiliates (Aetna) and the participating, independent providers in our network. Participating physicians are independent doctors who practice at their own offices and are neither employees nor agents of Aetna. Similarly, participating hospitals are neither owned nor controlled by Aetna. Likewise, other participating health care providers are neither employees nor agents of Aetna.

Participating Providers are paid on a 'Discounted Fee For Service' arrangement. Discounted fee for service means that participating providers are paid a predetermined amount for each service they provide. Both the participating provider and Aetna agree on this amount each year. This amount may be different than the amount the participating provider usually receives from other payers.

HIPAA

The following information describes the Late Enrollee and Portability provisions of the Health Insurance Portability and Accessibility Act of 1996 (HIPAA). It is not a part of your booklet-certificate.

Late Enrollee

A "Late Enrollee" is a person (including yourself) for whom you do not elect Health Expense Coverage within 31 days of the date the person becomes eligible for such coverage.

Enrollment Procedure

You may elect coverage for a Late Enrollee only during the annual late entrant enrollment period established by your Employer.

Coverage for a Late Enrollee will become effective on the first day of the second calendar month following the end of the late entrant enrollment period during which you elect coverage for the Late Enrollee.

Any preexisting condition limitation will apply to a Late Enrollee.

Exceptions

A person will not be considered to be a Late Enrollee if all of the following are met:

- you did not elect Health Expense Coverage for the person involved within 31 days of the date you were first eligible (or during an open enrollment) because at that time:
 - the person was covered under other "creditable coverage" as defined below; and
 - you stated, in writing, at the time you submitted the refusal that the reason for the refusal was because the person had such coverage; and
- the person loses such coverage because:
 - of termination of employment in a class eligible for such coverage;
 - of reduction in hours of employment;
 - your spouse dies;
 - you and your spouse divorce or are legally separated;
 - such coverage was COBRA continuation and such continuation was exhausted; or
 - the other plan terminates due to the employer's failure to pay the premium or for any other reason; and
- you elect coverage within 31 days of the date the person loses coverage for one of the above reasons.

As used above, "creditable coverage" is a person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such coverage includes coverage issued on a group or individual basis; Medicare; Medicaid; military-sponsored health care; a program of the Indian Health Service; a state health benefits risk pool; the Federal Employees' Health Benefit Plan (FEHBP); a public health plan as defined in the regulations; and any health benefit plan under Section 5(e) of the Peace Corps Act.

If you are not considered a Late Enrollee, Health Expense Coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.

Additional Exceptions

Also, a person will not be considered a Late Enrollee if you did not elect, when the person was first eligible, Health Expense Coverage for:

- A spouse or child who meets the definition of a dependent, but you elect it later and within 31 days of a court order requiring you to provide such coverage for your dependent spouse or child. Such coverage will become effective on the date of the court order. Any limitation as to a preexisting condition may apply.
- Yourself and you subsequently acquire a dependent, who meets the definition of a dependent, through marriage, and you subsequently elect coverage for yourself and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.
- Yourself and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.
- Yourself and your spouse and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself, your spouse, and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.

Special Rules as to a Preexisting Condition (Portability)

If a person had creditable coverage and such coverage terminated within 90 days prior to the date he or she enrolled (or was enrolled) in this Plan, then any limitation as to a preexisting condition under this Plan will not apply for that person.

Also, if a person enrolls (or is enrolled) in this Plan immediately after any applicable probationary period has been served, and that person had creditable coverage which terminated within 90 days prior to the first day of such probationary period, then any limitation as to a preexisting condition will not apply for that person.

As used above: "creditable coverage" means a person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. Such coverage includes the following: coverage issued on a group or individual basis, Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefits risk pool, the Federal Employees' Health Benefit Plan (FEHBP), a public health plan as defined in the regulations, and any health benefit plan under Section 5(e) of the Peace Corps Act.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, coverage will be provided to a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy for:

- (1) reconstruction of the breast on which a mastectomy has been performed;
- (2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
- (3) prostheses; and
- (4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.