

IMPORTANT NOTICE

AVISO IMPORTANTE

To obtain information or make a complaint:

Para obtener información o para someter una queja:

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

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

1-800-252-3439

1-800-252-3439

You may write the Texas Department of Insurance at:

Puede escribir al Departamento de Seguros de Texas:

Texas Department of Insurance  
P.O. Box 149104  
Austin, TX 78714-9104  
FAX No. (512) 475-1771

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P.O. Box 149104  
Austin, TX 78714-9104  
FAX No. (512) 475-1771

**Premium or Claim Disputes:**

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

**Disputas Sobre Primas o Reclamaciones:**

Si surge una disputa concerniente a su prima o a una reclamación, debe comunicarse con Aetna primero. Si no se resuelve la disputa puede comunicarse con el Departamento de Seguros de Texas.

**Notice:**

This notice is for information only and does not become a part or condition of your Certificate.

**Aviso:**

Este aviso es sólo para propósito de información y no se convierte en una parte o condición de su Folleto.

**THE GROUP CONTRACT UNDER WHICH THIS BOOKLET-CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.**

# Summary of Coverage

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**Employer:** PDS Technical Services

**Group Policy:** GP-809341

**SOC:** 1A

**Issue Date:** February 6, 2008

**Effective Date:** January 1, 2008

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 regular full-time employee and you are in an area in which there are Preferred Care Providers. Your Employer will provide you with this information.

Your Eligibility Date is the date you complete a probationary period of 90 days of continuous service for your Employer, 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 25 years of age.

Your children include:

- Your biological children.
- Your adopted children.
- Your stepchildren.
- Any child whom you support on the date of his or her initial application for coverage and whose parent is your child.
- Any other child whom you support who lives with you in a parent-child relationship.

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

### Open Choice

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**

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 within 31 days of your Eligibility Date.

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.

## **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 form.

If you don't sign and return your form within 31 days of your Eligibility Date, coverage will take effect as provided in the Late Enrollee information attached to the back of this Summary of 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 new dependents. This may affect your contributions. If you do not do so within 31 days of any dependent's eligibility date, coverage will take effect as provided in the Late Enrollee information attached to the back of this Summary of Coverage.

### **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 "adopted" which, for the purposes of this Plan, means that you have begun the legal process which would result in adoption; provided:

- such process begins after the date your coverage becomes effective; and
- you make written request for coverage for the child within 31 days of the date you begin such legal process.

Coverage for the child will become effective on the date the child is adopted. 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

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## 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.

Note: As described in the definition of “reasonable charge” in the Glossary, Aetna may have an agreement with a provider (either directly, or indirectly through a third party) which sets the rate payable in certain circumstances for a service or supply.

## Prescription Drug Expense Coverage

### Prescription Drug Benefits

#### *Payment Percentage*

100% 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	\$ 20	\$ 40
Brand Name Drugs		
On Medication Formulary	\$ 40	\$ 80
Not on Medication Formulary	\$ 70	\$ 140

50% as to:

Non-Preferred Pharmacy	
Generic Drugs	\$ 20
Brand Name Drugs	
On Medication Formulary	\$ 40
Not on Medication Formulary	\$ 70

\* but no more than a 90 day maximum supply.

# Comprehensive Medical Expense Coverage

All maximums included in this Plan are combined maximums between Preferred Care and Non-Preferred Care, where applicable, unless specifically stated otherwise.

## Certification Requirement

Certain types of care must be certified as necessary to avoid a reduction in the benefits payable. Read the Comprehensive Medical Expense Coverage section of the Booklet-Certificate for details of the types of care affected, how to get certification and the effect on your benefits of failure to obtain certification.

Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Skilled Nursing Care.

Excluded Amount \$ 400

This Excluded Amount applies separately to each type of admission and care listed above.

## The Benefits Payable

After any applicable deductible, the Health Expense Benefits payable 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. Benefits may vary depending upon whether a Preferred Care Provider is utilized. A Preferred Care Provider is a health care provider who has agreed to provide services or supplies at a "negotiated charge." See your Employer for a copy of the Directory which lists these health care providers.

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

## Deductible Amounts

Calendar Year Deductible

Preferred Care	\$ 1,200
Non-Preferred Care	\$ 2,000

When Covered Medical Expenses applied against a person's Calendar Year Deductible in any calendar year equal \$ 1,200, the Calendar Year Deductible will not apply to preferred care or other health care during the rest of that calendar year. Covered Medical Expenses incurred during the rest of that calendar year for preferred care and other health care will not be applied against the person's Calendar Year Deductible.

This Calendar Year Deductible applies to all expenses except:

The following expenses incurred for Non-Preferred Care:

- Child Hearing Care Expenses
- Emergency Care provided in an emergency room

The following expenses incurred for Preferred Care:

- Fees of a physician for non-surgical office visits
- Covered Medical Expenses incurred for a routine Pap smear
- Covered Medical Expenses incurred for a routine mammogram
- Routine screening for cancer of the prostate, including a digital rectal exam and a prostate specific antigen (PSA) test
- Immunization expenses
- Child Hearing Care Expenses
- Routine Physical Exam Expenses
- Urgent Care Expenses
- Emergency Care provided in an emergency room
- Routine Hearing Exam Expenses

Family Deductible Limit	
Preferred Care	\$ 3,600
Non-Preferred Care	\$ 6,000

If Covered Medical Expenses incurred in a calendar year by you and your dependents and applied against the separate Calendar Year Deductibles equal \$ 3,600, the Calendar Year Deductible will not apply to expenses incurred for preferred and other health care during the rest of that calendar year for you and your dependents.

Emergency Room Deductible	\$ 150 per visit
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This Emergency Room Deductible applies to Hospital Expenses incurred for emergency care provided by a Non-Preferred Care Provider. This amount is waived if the person becomes confined in a hospital.

Emergency Room Copay	\$ 150 per visit
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This Emergency Room Copay applies to Hospital Expenses incurred for emergency care provided by a Preferred Care Provider. This amount is waived if the person becomes confined in a hospital.

Urgent Care Copay	\$ 35 per visit
	This amount is waived if a person becomes confined in a <b>hospital</b> .

This Urgent Care Copay applies to all expenses for urgent care.

### **Payment Percentage**

The Payment Percentage applies after any deductible amounts.

#### ***For Hospital Expenses\****

Preferred Care	Non-Preferred Care
70%	50%

\* Emergency Room Treatment (Emergency Care), as defined by your Booklet-Certificate, will be covered at 100% after applicable deductible/copay.

#### ***For Physicians Fees Non-Specialist***

Preferred Care	Non-Preferred Care
Non-surgical Office Visits -100% after a \$ 25 copay	50%
Other - 70%	50%

#### ***Specialist***

Preferred Care	Non-Preferred Care
Non-surgical Office Visits - 100% after a \$ 35 copay	50%
Other - 70%	50%

**For Physical Exam Expenses**

Refer to applicable category of "Physician Fees" above.

**For Immunization Expenses**

Refer to applicable category of "Physician Fees" above. The copay is waived if in conjunction with an office visit that is only for immunizations for infectious disease.

**For Hospice Care Expenses**

For hospital charges refer to the applicable category of "Hospital Expenses" above.

For charges of a physician, refer to the applicable category of "Physician Fees" above.

For all other charges 70%

**For Durable Medical and Surgical Equipment**

Preferred Care Non-Preferred Care  
70% 50%

**Spinal Disorder Expenses**

Preferred Care Non-Preferred Care  
70% 50%

**For Other Covered Medical Expenses**

Covered Medical Expenses incurred for a routine mammogram

Preferred Care 100%  
Non-Preferred Care 70%

Covered Medical Expenses incurred in connection with routine screening for cancer of the prostate, including a digital rectal exam and a prostate specific antigen (PSA) test

Preferred Care 100% after applicable copay  
Non-Preferred Care 50%

100% as to:

National Medical Excellence Travel and Lodging Expenses

70% as to:

Convalescent Facility Expenses  
Home Health Care Expenses  
All Other Medical Expenses for which a Payment Percentage is not otherwise shown.

**Reduced Payment Percentage**

50% as to:

Non-emergency care in an emergency room.

**Payment Percentage and Special Maximums for Alcoholism and Drug Abuse**

Preferred Non-Preferred  
Care Care

***Alcoholism and  
Drug Abuse***

Inpatient Treatment	70%	50%
Outpatient Treatment	100% after \$ 35 copay	50%

Maximum Series  
of Treatments 3

**Payment Limits**

These limits apply only to Covered Medical Expenses which are payable at a rate greater than 50% and not applied against any deductible, copay amount, or penalty amount.

***Payment Limit which Applies to Expenses for a Person***

When a person's Covered Medical Expenses for which no benefits are paid because of the Payment Percentage reach \$ 5,000 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 in the rest of that calendar year, except those for Non-Preferred Care. When the amount reaches \$ 10,000, then benefits will be payable at 100% for all of his or her Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, including those for Non-Preferred Care.

***Payment Limit which Applies to Expenses for a Family***

When a family's Covered Medical Expenses for which no benefits are paid because of the Payment Percentage reach \$ 10,000 in a calendar year, benefits will be payable at 100% for all of their Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, except those for Non-Preferred Care. When the amount reaches \$ 20,000, then benefits will be payable at 100% for all of their Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, including those for Non-Preferred Care.

**Benefit Maximums**

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

Convalescent Days	90 per calendar year
Home Health Care Maximum Visits	120 per calendar year
Hospice Care	
Maximum Number of Days	30
Outpatient Maximum	\$ 5,000
Private Duty Nursing Care Maximum Shifts	70 per calendar year
National Medical Excellence	
Lodging Expenses Maximum	\$ 50
Travel and Lodging Maximum	\$ 10,000
Private Room Limit	The institution's semiprivate rate.

*Lifetime Maximum Benefit:* There is no Lifetime Maximum Benefit (overall limit) that applies to the Comprehensive Medical benefits described in the Booklet-Certificate. The only maximum benefit limits are those specifically mentioned in your Booklet-Certificate.

## **Pregnancy Coverage**

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

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.

*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.

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**

# Additional Information

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

**Employer Identification Number:**

See your employer

**Plan Number:**

See your employer

**Type of Plan:**

See your employer

**Type of Administration:**

Group Insurance Policy with:

Aetna Life Insurance Company  
151 Farmington Avenue  
Hartford, CT 06156

**Plan Administrator:**

PDS Technical Services  
1925 W. John Carpenter Fwy, 550  
Irving, TX 75063

**Agent For Service of Legal Process:**

PDS Technical Services  
1925 W. John Carpenter Fwy, 550  
Irving, TX 75063

**End of Plan Year:**

See your employer

**Source of Contributions:**

See your employer

**Procedure for Amending the Plan:**

The Employer may amend the Plan from time to time by a written instrument signed by your employer.

## ERISA Rights

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

### Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an 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.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

### Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse, or your 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 for the rules governing your COBRA 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 COBRA continuation coverage, when your COBRA 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 preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

### Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are 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 your interest and that of 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.

## Enforce Your Rights

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 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 materials 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 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. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a 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.

## **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, 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.

## **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.