The Women's Health and Cancer Rights Act of 1998

Effective for the plan year beginning October 1, 1999, for any participant or beneficiary of the University's Health Plans receiving Plan benefits for a mastectomy, federal law requires the Plan to make benefits available for the following expenses incurred in connection with a mastectomy:

Coverage for benefits required under the Act remains subject to any deductibles and co-payment amounts that are consistent with those that apply to other benefits under the Plan.

NOTICE:

Federal Law requires this plan to provide the following benefits for elective breast reconstruction in connection with a mastectomy:

(1) reconstruction of the breast on which the mastectomy has been performed;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
(3) Prostheses and physical complications in all stages of mastectomy, including lymph edemas; in a manner determined in consultation with the attending Physician and the patient. Such coverage is subject to all other plan terms and limitations.

Declining Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse/domestic partner) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, declaration of domestic partner relationship, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, declaration of domestic partner relationship, birth, adoption, or placement for adoption.

Maternity Benefits

Same as Any Other Illness for Covered Employees, Covered Spouses, Covered Domestic Partners or Covered Dependents, Parent and Child benefits are computed as one for initial birth expenses only.

The plan pays for initial routine newborn exam, newborn nursery charges and circumcision for Covered Newborn Dependents.

Maternity Coverage Notice

Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of the above periods. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours or ninety-six (96) hours, as applicable.

Utilization Review - 800.851.4630
(PPO Plan Only)

The Utilization Review Administrator must be notified prior to elective admission to the hospital or within forty-eight (48) hours after admission for Emergency Treatment or obstetric care. Failure to do so will result in a penalty in the form of a reduction in benefits otherwise computed. The reduction shall be the lesser of (1) actual benefits payable, or (2) $750.