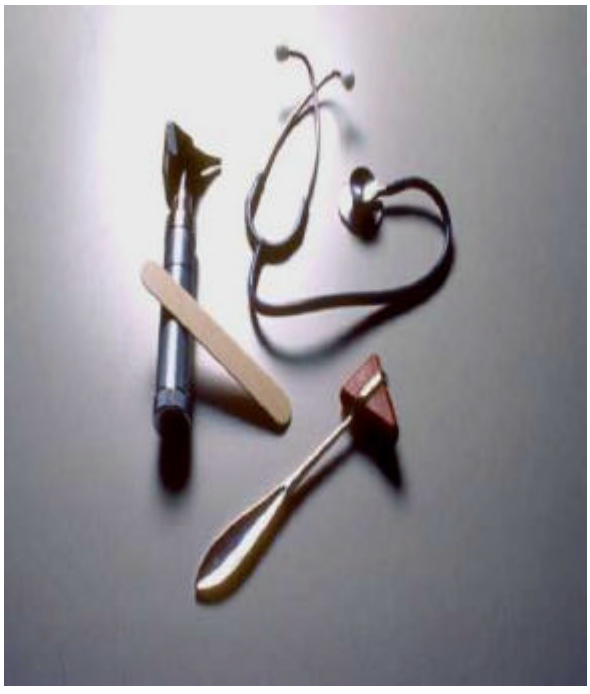
WHA

WESTERN HEALTH ADVANTAGE

University of California

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

2001



Finally, a health plan that works to your advantage . . .

2001

UC 106A

Group # 00-1021

(For Your Reference)

MEMBER NAME _____

ADDRESS _____

TELEPHONE NUMBER _____

ELIGIBILITY DATE _____

NAME OF PRIMARY CARE PHYSICIAN _____

PRIMARY CARE PHYSICIAN Ś ADDRESS _____

PHARMACY LOCATION _____

PHARMACY TELEPHONE NUMBER _____

24-HOUR EMERGENCY CARE TELEPHONE NUMBER _____

Plan Changes for 2001

Please make note of the following changes and/or clarifications to your plan effective January 1, 2000.

- To reflect the new benefit enhancements, the UC plan benefit code (the number on the top of your *Covered Services Summary* and inside your *Combined Evidence of Coverage and Disclosure Form)* will be UC106A.

- The office visit copayment for mental health is the same as any other illness with no limit on the number of visits, $5 per office visit. Outpatient services for medically necessary evaluation and short-term care are covered. (See page 11 for additional information about the behavioral health benefit.)

- All FDA-approved contraceptives requiring a prescription are covered. Most of these are covered under your pharmacy benefit but implantable devices and injectables are covered under the medical portion of your health plan. (*See the Covered Services Summary* for copayment amounts).

- Testing and treatment of Phenylketonuria (PKU) is now a covered benefit. This includes the cost of any special foods or formulas over and above a "regular diet". The special diet formula coverage is new and members will need to submit a claim to WHA for reimbursement.

- Supplies, equipment, and services for the treatment and/or control of diabetes, including outpatient self-management training, education, and medical nutrition therapy will be covered. This is an enhancement of your current benefit.

- You may request a second opinion regarding any diagnosis and/or any prescribed medical procedure. WHA members may choose any WHA 'Participating Provider' of the appropriate specialty to render the opinion. Second Opinions outside the WHA network must be authorized, and if approved, you may go to an out of network provider if there are no in network specialists available. All opinions performed by 'non-Participating Providers' require Prior Authorization from WHA or its delegated medical group. Decisions regarding second medical opinions will be rendered within the following timelines:

❖ Urgent/emergent conditions – within one working day
❖ Expedited conditions – within 72 hours
❖ Elective conditions – within five working days

If you have any questions, please feel free to contact our Member Services Department at (916) 563-2251 or (888) 563-2251, Monday through Friday between 8am and 5pm.

CONTENTS

CONTENTS

COVERED SERVICES SUMMARY PLAN UC 106A

UTPATIENT SERVICES	YOU PAY
ffice visits for medical and pediatric care	$ 5 per visit
/ell-baby care - birth to two years	Covered in full
aternity care, after the initial diagnosis, pre and ost-natal	Covered in full
urgical Procedures	$ 5 per visit
nmunizations (birth to two years)	Covered in full
(2 and over)	$ 5 per visit
eriodic physical examinations	$ 5 per visit
ffice visits for consultation or care by a non-primary rovider when referred by your primary care physician	$ 5 per visit
ye and hearing examinations (all ages)	$ 5 per visit
aboratory, x-ray, electrocardiograms and l other tests	Covered in full
llergy testing	$ 5 per visit
herapeutic injections, including allergy shots	$ 5 per visit
amily planning services	$ 5 per visit
nfertility testing and treatment services including drugs rovided	50% copay

NPATIENT HOSPITALIZATION	
emi-private room and board for acute care rivate room when determined medically ecessary by a participating provider)	Covered in full
hysicians 'services, including surgeons nd consultants	Covered in full
ospital specialty services including use of operating nd recovery room, anesthesia, inpatient drugs, -ray, laboratory, radiotherapy and nursery care r newborn babies	Covered in full
edical, surgical, and cardiac intensive care	Covered in full
rivate-duty nurse when prescribed by a participating hysician	Covered in full
lood transfusion services	Covered in full

KILLED NURSING FACILITY	
emi-private room and board in a skilled nursing facility, hen medically necessary and arranged by a primary care hysician, including drugs and prescribed ancillary services r up to 100 days in a calendar year	Covered in full

EHABILITATION SERVICES	
hort-term rehabilitative services including physical therapy, speech therapy, spiratory therapy or an organized program of such services.	
npatient Rehabilitation	Covered in full
utpatient Rehabilitation	$ 5 per visit

AXIMUM COPAYMENT LIABILITY

axiomum Copayment Liability per calendar year is limited to:

ndividual	$750
amily	$1,500

opayments for Prescription Medications do not contribute to the laximum Copayment Liability.

MENTAL HEALTH & CHEMICAL DEPENDENCY	YOU PAY
OUTPATIENT – Mental Health	
Outpatient services	$5 per visit
INPATIENT - Mental Health	
Inpatient hospital services provided at a participating acute care facility when authorized in advance by WHA	Covered in full
OUTPATIENT – Chemical Dependency	
Services for detoxification and for medical conditions associated with substance abuse	$5 per visit
Rehabilitation services.	$5 per visit
INPATIENT - Chemical Dependency	
Services for inpatient detoxification and for medical conditions associated with substance abuse at a WHA acute care facility, including rehabilitation services.	Covered in full

OTHER HEALTH SERVICES	
Home health care, when prescribed by a participating physician and determined to be medically necessary	Covered in full
Hearing Aids , one device per ear every 36 months ($2000 benefit maximum)	50% copay
Durable Medical Equipment and prosthetic/orthotic devices when determined by a participating physician to be medically necessary and prior authorized by WHA	Covered in full
Ambulance service when ordered by a participating physician as medically necessary or in a life-threatening emergency	Covered in full

URGENT AND EMERGENCY SERVICES WITHIN THE SERVICE AREA	
Care provided or authorized in advance by a participating physician at:	
Participating physician s office	$5 per visit
Participating urgent care facilities	$5 per visit
Participating hospital emergency rooms (no charge if admitted)	$25 per visit

URGENT AND EMERGENCY SERVICES OUTSIDE THE SERVICE AREA	
Outpatient Urgent Care services at an Urgent Care facility or Physician s office	$5 per visit
Outpatient Emergency Services	$25 per visit
Inpatient care to treat an injury or the sudden onset of an acute illness until your condition permits safe transfer to a participating facility	Covered in full

OUTPATIENT PRESCRIPTION MEDICATION

Only medications listed on the WHA drug formulary will be covered.

30-day supply: Generic copay of $5 and Brand Name copay of $10 (if no generic available). Generic required if available. Brand Name medication dispensed if requested by physician or member; the Member will pay the Generic copay **plus** the difference in cost between Generic and Brand Name. If there is no Generic equivalent, Brand Name copay of $10 applies.

Mail Order (90 day supply): Generic copay of $10, Brand Name copay of $20, with same provisions as above.

Drugs for the treatment of Sexual Dysfunction 50% copay

INTRODUCTION

Welcome to Western Health Advantage

Welcome to Western Health Advantage (WHA). We at WHA are pleased that you have chosen our health plan for your medical needs. The information in this Combined Evidence of Coverage and Disclosure Form was designed for you as a new Member to familiarize you with WHA. It describes the medical services available to you and explains how you can obtain treatment.

Please read this Combined Evidence of Coverage and Disclosure Form carefully and completely then keep it handy for reference while you are receiving medical services under WHA. It will help you understand how to get the care you need.

This Combined Evidence of Coverage and Disclosure Form is a summary of the group health plan. The Group Agreement between WHA and your Employer that has sponsored your participation in this health plan must be consulted to determine the exact terms and conditions of coverage. You may request to see the Group Agreement from your Employer.

By enrolling or accepting services under this health plan, Members are obligated to understand and abide by all terms, conditions and provisions of the Group Agreement and this Combined Evidence of Coverage and Disclosure Form.

This Combined Evidence of Coverage and Disclosure Form, the Group Agreement and benefits are subject to amendment in accordance with the provisions of the Group Agreement without the consent or concurrence of Members.

This Combined Evidence of Coverage and Disclosure Form, and the provisions within it are subject to regulatory approval by the Department of Managed Healthcare. Modifications of any provisions of this document to conform to any issue raised by the Department of Managed Healthcare shall be effective upon notice to the Employer; shall not invalidate or alter any other provisions; and shall not give rise to any termination rights other than as provided in this Combined Evidence of Coverage and Disclosure Form.

Members are obligated to inform WHA's Member Services Department of any change in residence and any circumstance, which may affect entitlement to coverage or eligibility under this health plan, such as Medicare eligibility. Members must also immediately disclose to WHA's Member Services Department whether they are or became covered under another group health plan, have filed a Workers' Compensation claim, were injured by a third party, or have received a recovery as described in this Combined Evidence of Coverage and Disclosure Form.

If you have any questions after reading this Combined Evidence of Coverage and Disclosure Form, or at any time, please contact Member Services at (916) 563-2251 or (888) 563-2251. They will be happy to help you. Thank you for choosing Western Health Advantage.

Choice of Physicians and Other Providers

As a Member of WHA, you have access to a large network of Participating Providers from which to choose your Primary Care Physician. These providers are conveniently located throughout the WHA Service Area. All non-Emergency care must be accessed through your Primary Care Physician. He or she is responsible for coordinating your health care from specialists and other medical providers. Referral requirements will be described later in this Combined Evidence of Coverage and Disclosure Form.

Facilities

WHA Participating Providers include a wide selection of Primary Care Physicians, specialists, hospitals, laboratories, pharmacies, ambulance services, skilled nursing facilities, home health agencies and other ancillary care services.

You will be provided with a copy of WHA's *Provider Directory*; however this list is subject to change as new providers contract with WHA and some Participating Provider contracts end. If you need another copy of the directory, contact Member Services at (916) 563-2251 or (888) 563-2251. The directory is also available through the WHA web site: www.westernhealth.com.

Liability of Member for Payment

Participating Providers

All non-Urgent Care and non-Emergency Care must be provided by your Primary Care Physician, his or her on-call Physician or a Participating Provider referred by your Primary Care Physician. WHA will not be liable for costs incurred if you seek care directly from a provider other than your Primary Care Physician.

Non-Participating Providers

Any coverage for services provided by a Physician or other health care provider who is not a participating WHA provider requires prior written authorization before the service is obtained, except in Urgent Care and Emergency Care situations when you are out of the

WHA service area. If payment is denied by WHA to a non-Participating Provider, you may be liable for the cost of these services.

Liability of Western Health Advantage

It is specified in WHA's contractual agreements with Participating Providers that you are not liable for payment for Covered Services, except for required Copayments. Copayments are fees that you pay to providers at the time of service. (See "Copayment" in the "Definitions" section.)

HOW TO USE WESTERN HEALTH ADVANTAGE

Selecting Your Primary Care Physician

When you enroll in WHA, you must select a Primary Care Physician for yourself and each of your covered Dependents. You may designate a different Primary Care Physician for each Member if you wish. Your Primary Care Physician is responsible for coordinating your health care by either direct treatment or referral to a participating specialist. All non-Urgent Care or non-Emergency care should be received from your Primary Care Physician or other Participating Provider as may be referred by your Primary Care Physician.

If you have never been seen by the Primary Care Physician you choose, please call his or her office before designating him or her as your Primary Care Physician. This will confirm that the practice is not temporarily closed and it will give the office the opportunity to explain any new patient requirements. The name of your Primary Care Physician will appear on your WHA identification card. If you do not designate a Primary Care Physician at the time of enrollment, WHA will assign one to you.

Changing Your Primary Care Physician

Since your Primary Care Physician coordinates all your covered care, it is important that you are completely satisfied with your relationship with him or her. If you want to choose a different Primary Care Physician, call Member Services **before** your scheduled appointment. Member Services will ask you for the name of the Physician and your reason for changing.

Once a new Primary Care Physician has been assigned to you, WHA will issue a new ID card confirming the Physician's name. In most cases, the effective date is the first day of the month following notification. You must wait until the effective date before seeking care from your new Primary Care Physician, or the services may not be covered.

Guaranteed Primary Care Access

WHA wants you to receive the care you need when you need it. In most cases, your Primary Care Physician will be available for urgent visits. However, we offer a unique program that ensures access to another primary care provider for acute medical needs (within one working day) if your Primary Care Physician is not available.

If you have an acute medical need, call your Primary Care Physician's office and request an immediate appointment. If, for any reason, your Primary Care Physician's office cannot arrange to see you, call WHA Member Services at (916) 563-2251 or (888) 563-2251 and we will assist you in obtaining a primary care appointment.

Referrals to Specialists

Advantage Referral Program

In order to expand the choice of specialists, WHA has implemented a unique program, the Advantage Referral Program, which allows you to access all specialists in our network rather than just those who have a direct relationship with your Primary Care Physician. Your Primary Care Physician will treat most of your health care needs. If he or she determines that your medical condition requires specialty care, you will be referred to an appropriate provider. You may, however, request to be referred to any of the WHA network specialists. In most cases, you will be comfortable with the specialist that your Primary Care Physician selects; however, if you already have a relationship with a network specialist, or prefer another network specialist, you may ask to be referred to him or her instead. The provider directory lists all of the network specialists approved for referrals by your Primary Care Physician. Self-referred annual well-woman exams, obstetrical services and annual eye exams are included in the Advantage Referral Program and do not require a PCP referral or prior authorization, as long as the provider is listed in the WHA provider directory. Any provider not listed in WHA's provider directory is a non-Participating Provider and you must obtain Prior Authorization from WHA before obtaining services.

Your Primary Care Physician will provide a written or verbal referral to your selected specialist. Please remember that if you receive care from a specialist without first receiving a referral, you may be liable for the cost of those services. You will receive a notification of the details of your referral and the number of visits as ordered by your physician. You need to bring this referral form to your appointment. If you receive a same-day appointment, the specialist will receive verbal

or fax authorization, which, along with your ID card, is sufficient.

The following services do not require a referral from your Primary Care Physician:

On-call Physician Services: The on-call physician for your Primary Care Physician can provide care in place of your physician.

Urgent Care and Emergency Care: In an extreme emergency, go to the nearest hospital Emergency Room, or call 911. (See "Urgent Care" and "Emergency" in the "Definitions" section.)

Gynecological Examination: A referral is not needed for gynecological services from a Participating Provider.

Obstetrical Services: A referral is not needed for obstetrical care from a Participating Provider.

Vision: Annual eye exams from a Participating Provider do not require a referral.

Prior Authorization

Certain Covered Services require Prior Authorization by WHA in order to be covered. This means that your Primary Care Physician must contact WHA (or in some cases, the participating medical group with which your Primary Care Physician is affiliated) to request that the service or supply be approved for coverage before it is rendered. Requests for Prior Authorization will be denied if the requested services are not Medically Necessary as determined by WHA.

Prior Authorization is required for services from non-Participating Providers (except in Urgent Care or Emergency situations). For example, a Covered Service may be Medically Necessary but not available from Participating Providers. Then, your Physician must obtain prior authorization from WHA or its delegated Medical Group before you receive services from a non-Participating Provider.

Any Prior Authorization is conditioned upon the Member being duly enrolled at the time the Covered Services are received. The Member will be responsible for the cost of any services not authorized by WHA and, if necessary, reimbursing WHA if the Member is not duly enrolled or if such services are provided after the date the Member's enrollment ceased.

Your WHA ID card alerts your provider that you are a WHA Member and that certain services will require Prior Authorization. If you do not present your ID card each time you receive services, he or she may fail to obtain Prior Authorization when needed, and you could be responsible for the resulting charges. Your Physician will receive written notice of authorized or denied services and you will be notified of any denials. If Prior Authorization is not received when required, you may be responsible for paying all of the charges. Please direct your questions about Prior Authorization to your Primary Care Physician.

Second Medical Opinions

A Member may request a second medical opinion regarding any diagnosis and/or any prescribed medical procedure. Members may choose any WHA Participating Provider of the appropriate specialty to render the opinion. All opinions performed by non-Participating Providers require Prior Authorization from WHA or its delegated Medical Group.

All requests for second medical opinions should be directed to the Member's Primary Care Physician. Members may also contact WHA's Member Services Department at (916) 563-2251 or (888) 563-2251 for assistance or for additional information regarding second opinion procedures. Decisions regarding second medical opinions will be rendered within the following timelines:

- Urgent/emergent conditions – within one working day
- Expedited condition – within 72 hours
- Elective conditions – within five (5) working days

Urgent Care and Emergency Care

WHA covers you for Urgent Care and Emergency Care services wherever you are in the world. Please note that Emergency room visits are not covered for non-Emergency situations. (See the "Definitions" section of this booklet for explanation of "Urgent Care" and "Emergency"). See the "Covered Services Summary" section for the applicable Copayments for Emergency room visits and urgent care facility visits.

If medical care is obtained from a non-Participating Provider, WHA will reimburse the provider for covered medical services received for Urgent Care or Emergency situations, less the applicable Copayment.

You can call your doctor at any time of the day, including evenings and weekends. Explain your condition to your doctor or the Physician on-call. If time does not permit such a call or if you are outside of the Service Area when the Urgent Care or Emergency situation occurs, go directly to the nearest Urgent Care or Emergency facility**. In an extreme emergency, go to the nearest hospital Emergency Room, or call 911.**

If you are hospitalized at a non-participating facility because of an Emergency, WHA must be notified within

48 hours or as soon as possible. This telephone call is extremely important. If you are unable to make the call, have someone else make it for you, such as a family member, friend or hospital staff member. WHA will work with the hospital and Physicians coordinating your care, make appropriate payment provisions and, if possible, arrange for your transfer to a participating hospital.

Follow-Up Care

Follow-up care after an emergency room visit is not considered an Emergency situation. If you receive Emergency treatment from an Emergency room Physician or non-participating Physician and you return to the Emergency room or Physician for follow-up care (for example, removal of stitches or redressing a wound), you will be responsible for the cost.

Call your Primary Care Physician for all follow-up care. If your health problem requires a specialist, your Primary Care Physician will refer you to an appropriate Participating Provider as needed.

Physician Access

Provider Network Adequacy. WHA will ensure the WHA provider network is adequate and that all covered services are accessible without unreasonable delay. This includes access to emergency services 24 hours a day and seven days per week.

Access to Qualified Specialists for Women's Health Services. WHA provides women access to participating providers (gynecologists, obstetricians, certified nurse midwives, and other qualified health care practitioners) for routine and preventive women's health services without the need for a referral.

Access to Specialists. Members with complex or serious medical conditions who require frequent specialty care can arrange for direct access to a network specialist. To ensure continuity of care, WHA can authorize referrals to a particular specialist for a chronic or serious medical condition for up to a year at a time, if applicable.

Transition and Continuity of Care. If appropriate new WHA members who must change health plans involuntarily and who are undergoing treatment for an acute or disabling condition, may be able to continue seeing their current provider until care can be transferred safely to a WHA network provider. You may request information from the Member Services Department at (916) 563-2251 or (888) 563-2251 or from WHA's web page (**www.westernhealth.com**).

Access to Emergency Services. Members have the right to access emergency health care services including the "911" emergency response system when and where the need arises. WHA has processes in place which ensure payment when a member presents to an emergency department with acute symptoms of sufficient severity – including severe pain – such that a "prudent layperson" or reasonable person could expect the absence of medical attention to result in placing the member's health in serious jeopardy.

CONSUMER BILL OF RIGHTS

General Information

WHA's Bill of Rights outlines the Member's rights and the Member's responsibilities as a Member of WHA. You may request a separate copy of this Member Bill of Rights by contacting our Member Services staff. It is also available on the WHA website.

A Member's rights include but are not limited to, the following:

- To exercise the foregoing rights without regard to age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, health status or the source of payment or utilization of services.
- To be provided with information about the managed care requirements of WHA, its services, its providers, and the Member's related rights and responsibilities.
- To be treated with respect and recognition of the Member's dignity and need for privacy.
- To participate actively in decisions regarding the Member's medical care, to the extent permitted by law, including the Member's right to refuse treatment.
- To have a candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- To voice complaints or appeals about WHA, or the care provided and to an appeals process to ensure resolution of a complaint or grievance.
- To provide, to the extent possible, information needed by professional staff to care for the Member.
- To follow preventive health guidelines, prescribed treatment plans and guidelines given by those providing health care services.
- To know the name of the physician who has primary responsibility for coordinating the care and the names and professional relationships of other physicians and non-physicians who will see the Member. This includes the provider's education,

certification or accreditation status, license status, and number of years in practice and experience performing certain procedures, along with the process used to measure quality and improvement of Member satisfaction.

- To receive information about the illness, the course of treatment and prospects for recovery in terms the Member can easily understand.
- To receive as much information about any proposed treatment or procedure as the Member may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment or non-treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment.
- To confidential treatment of all communications and records pertaining to the care and the stay in the hospital. Written permission shall be obtained before the medical records can be made available to anyone not directly concerned with the care, except as permitted by law or as necessary in the administration of WHA's health plan.

  Information from your medical records and such information from Providers or Hospitals shall be kept confidential. Except as is necessary in connection with administering the Group Agreement and fulfilling State and Federal requirements (including review programs to achieve quality medical care), such information will not be disclosed without your prior written consent. A complete copy of the "Confidentiality of Medical Records Policy" is available from WHA upon request.
- To reasonable responses to any reasonable request made for service.
- To full consideration of privacy concerning the Member's medical care program, case discussion, consultation, examination and treatment; these are confidential and should be conducted discreetly. The Member has the right to be advised as to the reason for the presence of any individual.
- To leave the hospital even against the advice of the attending physician.
- To reasonable continuity of care and to know in advance the time and location of appointment as well as the physician providing the care.
- To be advised if the physician proposes to engage in or perform human experimentation affecting the care or treatment; the patient has the right to refuse to participate in such research projects.
- To be informed of continuing health care requirements following discharge from the hospital or provider's office.
- To know which rules and policies apply to the Member's conduct.
- To examine and receive an explanation of the bill regardless of source of payment.
- Members have a right to access their medical records and to review and be given copies of their medical records in a timely manner. A patient may also request that their medical record be amended if it is not accurate, relevant or complete. The physician will have sole discretion in deciding to amend the record or not. If the physician does not amend the record, the member may add his or her own brief statement to the permanent medical record.
- To formulate advance directives for health care. To have the entire Member's rights apply as well to the person who may have legal responsibility to make decisions regarding medical care on behalf of the Member.

A Member's responsibilities include, but are not limited to the following:

- Knowing, understanding and abiding by the terms, conditions and provision of WHA health plan. This information is made available through this Combined Evidence of Coverage and Disclosure Form.
- Informing WHA's Member Services Department regarding any change in residence and any circumstance, which may affect entitlement to coverage or eligibility.
- Selecting a Primary Care Physician who has primary responsibility for coordinating the Member's care.
- Establishing and maintaining the patient-Primary Care Physician relationship.
- Learning about his or her medical condition and its significance to his or her well being.
- Participating actively in decision-making regarding his or her health care.
- Scheduling or rescheduling appointments and informing the physician when it is necessary to cancel an appointment.
- Being considerate and respectful to the medical staff and to other patients.
- Expressing grievances through WHA's grievance process regarding WHA or care, which was provided by a participating provider.

To facilitate greater communication between patients and providers, WHA will:

- Upon request, disclose to consumers factors such as: methods of compensation, ownership of or interest in healthcare facilities, or matters of

conscience that can influence advice or treatment decisions.

- Ensure that provider contracts do not contain any so-called "gag clauses" or other contractual mechanisms that restrict the healthcare provider's ability to communicate with or advise patients about medically necessary treatment options.

PRINCIPAL BENEFITS AND COVERED SERVICES

The following services and benefits are covered when determined to be Medically Necessary by WHA and provided by your Primary Care Physician or other Participating Providers to whom you have been referred by your Primary Care Physician. You will be responsible for all applicable Copayments as described in the "Covered Services Summary" section, and any charges related to non-Covered Services or limitations.

NOTE: A full description of exclusions and limitations can be found in the "Principal Exclusions and Limitations" section of this Combined Evidence of Coverage and Disclosure Form.

Outpatient Services:

The following outpatient services are covered under WHA. The "Covered Services Summary" defines the Member's Copayment responsibility.

- Office visits for adult and pediatric routine check-ups, well-baby care, and immunizations;
- Physician services in the Member's home, if the Member is too ill or disabled to be seen during regular working hours at the Physician's office. Member will pay the Copayment listed on the copayment Schedule Attachment listed for Physician office visits for each such visit;
- Pre-natal and post-natal maternity care;
- Gynecological exams; annual pap and pelvic;
- All generally medically accepted cancer screening tests, including pap smears, mammography screening or diagnostic, periodic prostate cancer screening, including prostate-specific antigen testing, digital rectal examinations, fecal occult blood tests, and flexible sigmoidoscopy subject to all terms and conditions that would otherwise apply;
- Testing and treatment of PKU, includes formula and special food products that are medically necessary and prescribed for treatment of PKU;
- Surgical procedures;
- Periodic physical examinations;
- Office visits for consultations or care by a non-participating specialist when referred and authorized by WHA or its delegated Medical Group;
- Eye examinations, (including annual eye refractions);
- Hearing examinations;
- Laboratory, x-ray, electrocardiograms and all other tests determined to be Medically Necessary;
- Therapeutic injections, including allergy testing and shots;
- Health education and family planning services (including counseling and examination); and
- Short-term rehabilitative services including physical therapy, speech therapy, occupational therapy, cardiac and pulmonary therapy are covered when authorized and determined to be medically necessary and when therapy is determined by WHA to lead to continued improvement of the member's condition.

NOTE: Some outpatient services, such as diagnostic testing, x-rays, and surgical procedures require Prior Authorization. For clarification you should contact WHA's Member Services.

Inpatient Services:

NOTE: All inpatient hospitalization requires Prior Authorization, except in an Emergency situation.

The following inpatient services are covered under WHA and are subject to the Copayment requirements as defined in the Covered Services Summary.

- Semi-private room and board (private room when determined to be Medically Necessary by a Participating Provider);
- Physician's services including surgeons, medical consultants, and anesthesia services;
- Hospital specialty services including use of operating room and recovery room, anesthesia, inpatient drugs, x-ray, laboratory, radiation therapy and nursery care for newborns;
- Medical, surgical, and cardiac intensive care;

- Private-duty nurse when prescribed by a Participating Provider;

- Blood transfusion services; and

- Physical therapy, occupational therapy, and speech therapy are inpatient benefits if coincidental with an admission for a benefit, which is covered under WHA.

Mental Health and Chemical Dependency:

Inpatient – Mental Health

Inpatient hospital services provided at a participating
Acute care facility when authorized in advance by WHA.

We cover treatment in a structured multi-disciplinary program as an alternative to inpatient psychiatric care. Hospital alternative services include partial hospitalization and treatment in an intensive outpatient psychiatric treatment program.

Outpatient - Mental Health

- Outpatient services for evaluation and short-term care when determined to be medically necessary.

Inpatient – Chemical Dependency

- Services for inpatient detoxification and for medical conditions associated with substance abuse at a WHA acute care facility, including rehabilitation when authorized in advance by WHA.

Outpatient - Chemical Dependency

- Outpatient services for detoxification and for the treatment of medical conditions associated with substance abuse from a Participating Provider are a covered benefit. Rehabilitation services are also covered.

Other Health Services:

- Short-term intermittent **Home Health Care Services** when prescribed by a Participating Provider and determined to be Medically Necessary. This benefit does not include meals, housekeeping, childcare, personal comfort or convenience items, services or supplies.

- **Hospice** services are covered with Prior Authorization. A Member may elect Hospice services in lieu of traditional acute care services and benefits if he or she is diagnosed with a terminal illness. Hospice services include: nursing care, medical social services and home health services. Hospice services are covered unless otherwise available without charge through community support services.

- Short term **skilled nursing facility** care to a maximum of 100 days in each calendar year.

- **Durable Medical Equipment (DME), Prosthetic Devices and Orthotic Devices** when prescribed by a Participating Provider and determined to be Medically Necessary. Examples of DME include: a standard wheelchair, oxygen and oxygen equipment. Orthotic devices include special footwear that is Medically Necessary as a result of foot disfigurement. Disfigurement includes: cerebral palsy, arthritis, polio, spina bifida, diabetes and accidental or developmental disabilities.

  a) WHA may, in its sole discretion, directly order or coordinate the ordering of the covered device and make the determination whether the covered device should be purchased or rented.

  b) Wheelchairs provided as a benefit under this health plan are limited to standard wheelchairs. A standard wheelchair is one that meets the minimum functional requirements of the Member.

  c) Where two or more alternative covered devices are appropriate to treat the Member's condition, the most cost effective device will be covered.

  d) Coverage for covered devices is limited to the basic type of DME, external Prosthetic device or external Orthotic device that WHA determines to be necessary to provide for the Member's medical needs.

  e) The allowable cost of covered devices will not be applied toward similar services and supplies that are not covered devices.

- **Reconstructive Surgery** to improve function or to create a normal appearance, to the extent possible or repair "abnormal structures" of the body that are caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease.

- **Breast prostheses** and reconstructive surgery incident to a mastectomy to restore and achieve symmetry is covered in full. Prosthetic devices and reconstructive surgery for a healthy breast is also covered if, in the opinion of the attending physician

and surgeon, this surgery is necessary to achieve normal symmetrical appearance.

- **Diabetic supplies, equipment, and service**, including outpatient self-management training education and medical nutrition therapy.

- **Hearing** aids are covered at a 50% copay with a $2000 benefit maximum; limited to one device per ear every 36 months.

- **Norplant** and other internally implanted time-release medications or contraceptives are covered at a Copayment approximating the aggregate charges that would be paid for an alternative, conventional drug therapy, but not more than $200. One insertion is covered every five years when provided by a Participating Provider. Voluntary removal prior to the five-year expiration date is not a covered benefit.

- **Infertility services** are covered including testing, consultations, examinations, diagnostic surgical services related to hospitalizations or facilities, and drug therapy. Services are covered at 50% of WHA's contracted rates when obtained with prior authorization.

- **Artificial insemination** services are limited to one treatment period of up to three cycles per Lifetime. Gamete interfallopian transfer ("GIFT") is not covered. Zygote interfallopian transfers are excluded. Artificial insemination services are not covered in the event the Member has undergone a voluntary sterilization procedure.

Emergency Medical Transport Services:

- Transport services are covered when ordered by a Participating Provider and determined to be Medically Necessary. **Transportation services (ambulance services, including those offered through the "911" emergency response system) are also covered for a life-threatening medical Emergency.**

Prescription Medication Benefits:

WHA shall cover prescription medications at participating pharmacies. Copayments for covered medications are described in the Covered Services Summary. Only medications listed on the WHA drug formulary will be covered. Covered prescription medications include:

- Medications, excluding injectables, which are Medically Necessary, approved by the Federal Drug Administration, are not experimental, which require a prescription by state or federal law, are written by a Participating Provider and dispensed by a participating pharmacy;

- All FDA approved contraceptives and diaphragms;

- Compounded prescriptions which contain at least one prescription ingredient;

- Insulin, insulin syringes with needles; lancets, ketone urine testing strips, and blood glucose meter testing strips;

- Prescription prenatal vitamins or vitamins in conjunction with fluoride.

- Viagra and other episodic medications for the treatment of sexual dysfunction are covered at a 50% copay. Viagra is limited to 8 pills per 30-day supply.

Covered medications dispensed by a non-participating pharmacy outside of WHA's Service Area for Urgent Care or Emergency care only. **Maximum 10 day supply**. You should submit your receipt to WHA for reimbursement within 60 days of purchase. Your Copayment amount will be deducted from your reimbursement.

PRINCIPAL EXCLUSIONS AND LIMITATIONS

The following services and supplies are excluded from coverage and, therefore, are not covered by WHA:

Exclusions:

- Any services or supplies obtained prior to the Member's effective date of coverage.

- Service and supplies which are not Medically Necessary.

- Non-Urgent Care or Non-Emergency services and supplies rendered by non-Participating Providers without written referral by the Member's Primary Care Physician. Care by non-Participating Providers will only be provided as a Covered Service if the care is not available through Participating Providers and determined to be Medically Necessary.

- Experimental medical or surgical procedures, services or supplies. Please refer to the "Definitions" section for "Experimental" criteria.

- Long-term care benefits including skilled nursing care and respite care are excluded except as determined by WHA to be less costly alternatives to the basic minimum benefits.

- Cosmetic services and supplies are excluded, except for reconstructive surgery and Prosthetic Devices incident to a mastectomy, as described in the "Principal Benefits and Covered Services" section (see page 11) . The exclusion includes services and supplies performed in connection with the reformation of sagging skin, the enlargement, reduction or change in the appearance of a portion of the body, hair transplant or analysis, chemical face peels or abrasions of the skin.

- Speech, Occupational and Physical Therapy which is **not** secondary to a medical condition, but is a result of one of the following conditions:

  a) Psychosocial speech delay and language development;

  b) Mental Retardation, Downs Syndrome, Autism or Dyslexia;

  c) Other syndromes attributing to perceptual and conceptual dysfunctions, attention deficit disorder or behavioral problems; or

  d) Developmental articulation and other language disorders.

- Penile Prostheses are excluded unless prescribed by a Participating Physician and determined to be Medically Necessary (e.g., secondary to penile trauma, tumor, or physical disease to the circulatory system or nerve supply), and are not of a psychological cause.

- Non-Emergency medical transport inside or outside the Service Area, except with Prior Authorization.

- Vision therapy, surgical procedures for the correction of visual acuity in lieu of eyeglasses or contact lenses (except for intraocular lenses in connection with cataract removal). Eyeglasses and contact lenses are excluded.

- Services or supplies in connection with the storage of body parts, fluids or tissues, except for autologous blood.

- Dental care, except for (1) non-dental surgical and hospitalization procedures incidental to facial fractures, tumors or congenital defects, such as cleft lip or cleft palate, or (2) Surgery on the maxilla or mandible to correct temporomandibular joint disease (TMJ) or other medical conditions, when Medically Necessary and Prior Authorized. Other dental services excluded include:

  a) Items or services in connection with the care, treatment, fillings, removal, replacement, or artificial restoration of the teeth or structures directly supporting the teeth.

  b) Treatment of dental abscesses, braces, bridges, dental plates, dental prostheses or dental orthoses, including anesthetic agents or drugs used for the purpose of dental care.

- Any services or supplies provided by a person who lives in the Member's home, or by an immediate relative of the Member.

- Personal comfort or convenience items (e.g., television, radio), home or automobile modifications, or improvements (e.g., chair lifts, purifiers).

- Vitamins (except prenatal prescription vitamins or vitamins in conjunction with fluoride).

- Routine foot care (e.g., treatment of or to the feet for corns, calluses or toenails), except when Medically Necessary. This exclusion includes Orthotic Devices for routine foot care. This exclusion does not include special footwear incident to foot disfigurement.

- Chiropractic services, acupuncture, acupressure, biofeedback, sex therapy, dance therapy and recreational therapy.

- All immunizations required by an Employer as a condition of employment.

- Embryo transfers and any services and supplies related to donor sperm or sperm preservation for artificial insemination.

- Services and supplies in connection with the reversal of voluntary sterilization.

- Transsexual surgery.

- Custodial care, or services and supplies furnished by an institution, which is primarily a place for rest and provides primarily non-nursing supervision of the patient. Other excluded services include homemaker services and convalescent care.

- Non-prescription weight loss aids and programs and non-participating provider programs.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

- Smoking cessation products and programs.

- Repair and replacement of DME, Orthotics or Prosthetics, when necessitated by the Member's abuse, misuse or loss. Any device not medical in nature, (e.g., exercise equipment, whirlpool, spa), more than one device for the same body part, or more than one piece of equipment that serves the same function.

- Orthotic Devices that enable the Member to participate in athletic activity, whether this activity is prior to any injury or as a part of the medical recovery service.

- Food supplements or infant formulas except for the treatment of PKU.

- Over-the-counter supplies or equipment that may be obtained without a prescription except for the treatment of diabetes.

- Services and supplies that are in connection with the donation of organs, except for services related to Medically Necessary non-experimental organ transplants where the Member is the organ recipient.

- Court ordered health care services and supplies when not Medically Necessary.

- Travel expenses including room and board even if the purpose is to obtain a Covered Service.

- Expenses incurred for the purpose of obtaining copies of the medical records if requested by the Member for personal use.

- Weight control surgery or procedures including, without limitation, gastric bubble, gastroplasty, gastric bypass, gastric stapling, liposuction, HCG injections and any Experimental Procedures for the treatment of obesity. However, Medically Necessary services as determined by WHA, for the treatment of morbid obesity are a covered benefit.

- Testing for the sole purpose of determining paternity.

- Services and supplies for any condition where the Member is entitled to care or reimbursement through the Veteran's Administration or any other government program. This includes Medicare. If WHA provides services to a Member who is covered by a government program, WHA or its nominee is entitled to any reimbursement from that program for which the Member is eligible. If a Member has recovered the value of such services from one of these programs, the Member shall pay WHA the amount recovered up to the value of such services, supplies or both as specified in a reimbursement schedule established by WHA.

Limitations

- All benefits for Covered Services are provided in connection with determining Medical Necessity. The services and supplies for diagnosing and treating any disease, illness, mental condition or injury must be in accordance with WHA's standards and medical policies for clinical effectiveness.

- Services and supplies rendered by non-Participating Providers are covered for Urgent Care and Emergency Care only, or when a Participating Provider is not available through the participating panel and Prior Authorization has been obtained.

- Physical, speech, and occupational therapy and cardiac and pulmonary rehabilitation are limited to short-term rehabilitation services, where significant improvement of the Member's medical condition can be expected to result.

- Physical exams and/or laboratory, x-ray or other diagnostic tests ordered in conjunction with a physical exam will **not** be a covered benefit if the purpose of the test is exclusively to fulfill an employment, licensing, sports, or school requirement.

- If services or supplies are received while a Member is entitled to benefits from another health plan, or for which a Member is entitled to collect damages due to a third party's liability, including Workers' Compensation, a Member is required to assist in the assignment, the liens and recovery of any WHA expense; or the Member is required to reimburse WHA for any expense incurred by WHA. Members not legally required to be covered by Workers' Compensation benefits are eligible for 24 hour coverage under WHA.

- WHA will not be held liable for the lack of available services in the event of a major disaster, epidemic, war, riot or other like circumstances beyond the control of WHA, which renders a Participating Provider unable to provide services. However, Participating Providers will provide or attempt to arrange for Covered Services according to their best judgment within the limitations of available facilities or personnel.

For Covered Services, WHA reserves the right to coordinate your care in a cost effective and efficient manner.

Prescription Medication Exclusions and Limitations

The covered prescription medications described in this Evidence of Coverage and Disclosure Form are subject to the exclusions and limitations set forth below:

- Only medications listed on the WHA drug formulary will be covered.
- Generic medications are required. Brand Name medication is dispensed if requested by physician or member; the Member will pay the Generic copay plus the difference in cost between Generic and Brand Name. If there is no Generic equivalent, Brand Name copay applies.
- Covered prescription medications are limited to a 30-day supply, with the payment of a single Copayment. Prescriptions for controlled substances and other drugs not intended for continuous use may be limited to a smaller quantity per Copayment.
- Covered prescription medications that are to be taken beyond 60 days are considered maintenance medications, and may be obtained through WHA's Mail Order Program. The initial prescription for maintenance medications may be dispensed through a Participating Pharmacy (limited to a 30-day supply). Subsequent refills for a 90-day supply may be obtained with the payment of two 30-day copayments through the mail order program.
- Viagra and other episodic drugs for the treatment of sexual dysfunction are covered at a 50% copay. Viagra is limited to 8 pills per 30 day supply.
- Over-the-counter medications or medications that do not require a prescription are excluded (except for insulin and insulin syringes with needles for diabetics, and except for other supplies and equipment for the treatment of diabetes).
- Medications that are not Medically Necessary are excluded.
- Prescription medications not on the WHA drug formulary are excluded unless Prior Authorized by WHA.
- Medications that are experimental or not approved for use by the FDA for the condition or indication are excluded. FDA Approved Drugs are those drugs, medications and biologicals approved by the Food and Drug Administration and listed in the United States Pharmacopoeia, the AMA Drug Evaluations and/or the American Hospital Formulary.
- Medications that are investigational are excluded, except for those medications approved by the FDA as Treatment Investigational New Drugs or classified as Group C 'cancer drugs by the National Cancer Institute ("NCI") to be used only for the purposes approved by the FDA or the NCI, when Prior Authorized by WHA.
- Prescriptions written by dentists are excluded.
- Nicotine gum, nicotine nasal spray and nicotine patches are excluded.
- Some prescription medications may require Prior Authorization. For clarification, please contact the Member Services Department.

BECOMING AND REMAINING A MEMBER OF WESTERN HEALTH ADVANTAGE

Who is Eligible

The University of California establishes its own medical plan eligibility criteria for Employees and Annuitants based on the University of California Group Insurance Regulations. Portions of these regulations are summarized below.

If you live or work in the Western Health Advantage (WHA) Service Area (all of Sacramento, El Dorado and Yolo Counties and parts of Solano, and Placer Counties), and meet both the University's and the Plan's eligibility criteria, you may enroll in the Plan. If you live or work in Solano or Placer County, contact the Member Services Department to determine if you are eligible for the Plan.

Subscriber

Employee:

You are eligible if you are appointed to work at least 50% time for one year or more or are appointed at 100% time for three months or more. To remain eligible, you must maintain an average regular paid time of at least 20 hours per week and maintain an eligible appointment of at least 50% time. If your appointment is at least 50% time, your appointment form may refer to the time period as follows: "Ending date for funding purposes only; intent of appointment is indefinite (for more than one year)."

Annuitant (including Survivor Annuitant):

You may continue University medical plan coverage when you retire or start collecting disability or survivor benefits from the University of California retirement plan, or any other defined benefit plan to which the University contributes. These conditions apply provided:

1) You were in a University medical plan immediately before retiring;

2) The effective date of your annuitant status is within 120 calendar days of the date employment ends (or the date of the Employee/Annuitant's death in the case of a Survivor Annuitant);

3) Your medical coverage is continuous from the date employment ends;

4) You elect to continue coverage at the time of retirement; and

5) You meet the University's service credit requirements for Annuitant medical eligibility.

Eligible Dependents

Spouse: Your legal spouse, except if you are a Survivor Annuitant you may not enroll your legal spouse.

Child: Any of your natural or legally adopted children who are unmarried and under age 23.

The following children are also eligible:

a) Any unmarried stepchildren under age 23, who reside with you, who are dependent upon you or your spouse for at least 50% of their support and who are your or your spouse's dependents for income tax purposes.

b) Any unmarried grandchildren under age 23, who reside with you, who are dependent upon you or your spouse for at least 50% of their support and who are your or your spouse's dependents for income tax purposes.

c) Any unmarried children under age 18 for whom you are the legal guardian, who reside with you, who are dependent upon you for at least 50% of their support and who are your dependents for income tax purposes.

Your signature on the enrollment form, or, if you enroll electronically then your electronic enrollment, attests to these conditions in (a), (b) and (c) above. You will be asked to submit a copy annually of your Federal income tax return (IRS form 1040 or IRS equivalent showing the covered dependent and your signature) to the University to verify income tax dependency.

Any unmarried child, as defined above (except for a child for whom you are the legal guardian), who is incapable of self-support due to a physical or mental handicap may continue to be covered past age 23 provided: the child is dependent upon you for at least 50% of his or her support, is your dependent for income tax purposes, the incapacity began before age 23, the child was enrolled in a medical plan before age 23 and coverage is continuous. Application must be submitted to WHA 31 days prior to the child's 23rd birthday and is subject to approval by the Plan. WHA may periodically request proof of continued disability. Your signature on the enrollment form, or, if you enroll electronically then your electronic enrollment, attests to these conditions. You will be asked to submit a copy annually of your Federal income tax return (IRS form 1040 or IRS Equivalent showing the covered dependent and your signature) to the University to verify income tax dependency.

Incapacitated children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan. If enrollment is transferred from one plan to another, a new application for continued coverage is not required.

If you are a newly hired Employee with an over-age, incapacitated dependent child, you may apply for coverage for that child under the same general terms as a current Employee. The child must have had continuous group medical coverage since age 23, and you must apply for coverage during your "Period of Initial Eligibility".

If the covered handicapped child is not the Employee's, Annuitant's, or Survivor Annuitant's natural or legally adopted child, the child must reside with the Employee, Annuitant, or Survivor Annuitant in order for the coverage to be continued past age 23.

Other Eligible Dependents:

You may enroll an adult dependent relative or same-sex domestic partner and their eligible children as set forth in the University of California Group Insurance Regulations. For information on who qualifies and on the requirements to enroll an adult dependent relative

or same-sex domestic partner, contact your local Benefits Office.

Eligible persons may be covered under only one of the following categories: as an Employee, as an Annuitant, as a Survivor Annuitant, or as a dependent, but not under any combination of these. If both husband and wife are eligible, each may enroll separately or one may cover the other as a dependent. If they enroll separately, neither may enroll the other as a Dependent. Eligible children may be enrolled under either parent's coverage, but not under both.

The University and/or WHA reserve the right to periodically request documentation to verify eligibility of dependents. Such documentation could include a marriage certificate, birth certificate(s), adoption records, or other official documentation.

Enrollment

You may enroll yourself and any Eligible Dependents during your Period of Initial Eligibility (PIE). The PIE starts the day you become eligible for benefits or acquire a newly Eligible Dependent.

You may enroll your newly Eligible Dependent during his or her PIE. The PIE starts the day your Dependent becomes eligible for benefits.
For a new spouse, eligibility begins on the date of marriage. Survivor Annuitants may not add new spouses to their coverage.

For a newborn child, eligibility begins on the child's date of birth.

For newly adopted children, eligibility begins on the earlier of:

a) The date the Employee or Employee's spouse has the legal right to control the child's health care, or

b) The date the child is placed in the Employee's physical custody.

If not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date that the adoption becomes final.

If you decline enrollment for yourself or your eligible dependents because of other medical plan coverage and that coverage ends, you may in the future be able to enroll yourself or your eligible dependents in a medical plan for which you are eligible provided that you enroll within the PIE. The PIE starts on the day the other coverage is no longer in effect.

If you move or are transferred out of a University HMO plan's service area, or will be away from the plan's service area for more than two months, you will have a PIE to enroll in another University medical plan. The PIE begins with the effective date of the move or the date the Employee leaves the service area.

A PIE ends on the date 31 days after it begins (or on the preceding business day for the local Accounting or Benefits Office if the 31st day is on a weekend or a holiday).

To enroll yourself or an eligible dependent, submit the appropriate enrollment form to the local Accounting or Benefits Office (or enroll electronically) during the PIE.

You and your eligible dependents may also enroll during a group open enrollment period established by the University.

If you or your eligible dependent fail to enroll during a PIE or open enrollment period, you may enroll at any other time upon completion of a 90 consecutive calendar day waiting period. The 90 day waiting period starts on the date the enrollment form is received by the local Accounting or Benefits Office and ends 90 consecutive calendar days later.

An Employee who currently has two or more covered dependents may add a newly eligible dependent after the PIE. Retroactive coverage for such enrollment is limited to the later of:

a) a maximum of 365 days prior to the date your Dependent is enrolled (either by receipt of their enrollment form by the local Accounting or Benefits Office or by electronic enrollment), or

b) the date the Dependent became eligible.

Effective Date of Coverage

Coverage for newly eligible Employees and their dependents is effective on the date of eligibility provided they are enrolled (either by receipt of an enrollment form by the local Accounting or Benefits Office or by electronic enrollment) within the PIE.

Coverage for newly eligible dependents is effective on the date the Dependent becomes eligible provided they are enrolled (either by receipt of an enrollment form by the local Accounting or Benefits Office or by electronic enrollment) within the PIE. There is one exception to this rule: coverage for a newly eligible adopted child enrolling during the additional PIE is effective on the date the adoption becomes final.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

For enrollees who complete a 90-day waiting period, coverage is effective on the 91st consecutive calendar day after the date the enrollment form is received by the local Accounting or Benefits Office.

The effective date of coverage for enrollment during an open enrollment period is the date announced by the University.

In order to change from individual to two-party coverage and from two-party to family coverage, you will need to complete a new enrollment form at the local Accounting or Benefits Office (or enroll electronically) within the PIE following the event, e.g., marriage, birth.

Loss of Eligibility

If you or your enrolled dependents cease to meet the eligibility requirements of WHA (see the "Who is Eligible" section), your coverage will terminate at midnight on the last day of the month in which loss of eligibility occurs, unless otherwise specified in your group agreement. WHA must be notified immediately if you or your dependents cease to meet eligibility requirements.

Your spouse loses eligibility if:

- You divorce.
- You become legally separated.

Your children lose eligibility as dependents if they:

- Marry, regardless of age.
- Reach the age limits for continuing group coverage or cease to meet other eligibility requirements for dependency status.

Loss of eligibility does not affect your right to continue group coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as described below.

Optional Continuation of Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, enrolled persons who would lose coverage under the Western Health Advantage medical plan due to certain "Qualifying Events" are entitled to elect, without having to submit evidence of good health, continued coverage at their own expense. Continued coverage shall be the same as for active eligible Employees and their Eligible Dependents under the University group plan. If coverage is modified for active eligible Employees and their Eligible Dependents, it shall also be modified in the same manner for persons with continued coverage (Qualified Beneficiaries) and an appropriate adjustment in premiums may be made.

Right to Continue Benefits

A right under this part is subject to the rest of these provisions:

You have the right to continue benefits under the plan for yourself and any enrolled Dependents if your coverage would have ended for either of the following Qualifying Events:

a) Because your employment ended for a reason other than gross misconduct; or

b) Because your work hours were reduced (including approved leave without pay or layoff).

Each of your Eligible Dependents has the right to continued benefits under the plan under the following circumstances:

In the case of your Eligible Dependent spouse, your spouse may continue coverage for himself or herself and for any enrolled Dependent children if your spouse's coverage would have ended because of any of the following Qualifying Events:

a) Because your employment ended for a reason other than gross misconduct; or

b) Because your work hours were reduced (including approved leave without pay or layoff); or

c) At your death; or

d) Because you become entitled to Medicare benefits; or

e) When your spouse ceased to be an Eligible Dependent as a result of divorce, legal separation or annulment.

If coverage ends under (e) immediately above, please see "**Notice**" below.

In the case of your eligible dependent child, your child may continue coverage for himself or herself if your child's coverage would have ended because of any of the following Qualifying Events:

a) Because your employment ended for a reason other than gross misconduct; or

b) Because your work hours were reduced (including approved leave without pay or layoff); or

c) At your death; or

d) Because you became entitled to Medicare benefits; or

e) Because of your divorce, legal separation, or annulment; or

f) When your Eligible Dependent child ceased to be an Eligible Dependent under the rules of the plan.

If coverage for an Eligible Dependent ends due to the event shown in (e) or (f) immediately above, please see "**Notice**" below.

For the Qualifying Event (a) or (b), if you become entitled to Medicare due to age within 18 months before the qualifying event, your Eligible Dependent spouse or your Eligible Dependent child may continue COBRA coverage for up to 36 months counted from the date you become entitled to Medicare.

If a second Qualifying Event occurs to a Qualifying Beneficiary who already has continuation coverage because employment has ended or work hours were reduced, that Qualifying Beneficiary's coverage may be continued up to a maximum of 36 months from the date of the first Qualifying Event.

Notice

If your coverage for an Eligible Dependent ends due to your divorce, legal separation or annulment, or if your Eligible Dependent child ceased to be an Eligible Dependent under the rules of the plan, you or your Eligible Dependent must give written notice of the event to the Employer at the local Benefits Office within sixty (60) days of the event or eligibility to elect continuation of coverage will be lost.

Continuation

Once aware of a Qualifying Event, the Employer will give a written election notice of the right to continue the coverage to you (or to the Qualified Beneficiary in the event of your death). Such notice will state the amount of the premium required for the continued coverage. If a person wants to continue the coverage, the Election Notice must be completed and returned to the address below, along with the first month's premium within sixty (60) days of the later of: (1) the date of the Qualifying Event; or (2) the date the Qualified Beneficiary received notice informing the person of the right to continue.

Western Health Advantage
Attn. COBRA Enrollment Department
1331 Garden Highway, Suite 100
Sacramento, CA 95833-9773
(916) 563-2251 or (888) 563-2251

Benefits of the continuation plan are identical to this group medical plan and cost is explained in "Cost of Continuation of Coverage" on page 20.

The continued coverage period runs concurrently with any other University continuation provisions (e.g., during leave without pay) except continuation under the Family and Medical Leave Act (FMLA). Coverage will be continued from the date it would have ended until the first of these events occurs:

1) With respect to yourself and any of your Qualified Beneficiaries the day 18 months from the earlier of the date:

   a) your employment ends for a reason other than gross misconduct, or

   b) your work hours are reduced. But, coverage may continue (at an increased cost) for all Qualified Beneficiaries for up to 11 additional months while the Qualified Beneficiary is determined to be disabled under Title II or XVI of the United States Social Security Act if:

      i) the disability was determined to exist at the time, or during the first 60 days of the 18 months of COBRA coverage; and

      ii) the person gives WHA written notice of the disability within sixty (60) days after the determination of disability is made and within 18 months after the date employment ended or work hours were reduced.

   WHA must be notified if there is a final determination under the United States Social Security Act that the person is no longer disabled. The notice must be provided within thirty (30) days after the final determination. The coverage will end on the first of the month that starts more than thirty (30) days after the determination.

2) With respect to your Qualified Beneficiaries (other than yourself), the day 36 months from the earliest of the date

   a) of your death; or

b) of your entitlement to Medicare benefits; or

c) of your divorce, annulment, or legal separation from your spouse; or

d) your Dependent child ceases to be an Eligible Dependent under the rules of the Plan.

The 36 months will be counted from the date of the earliest Qualifying Event.

With respect to any Qualified Beneficiary:

3) If the person fails to make any premium payment required for the continued coverage, the end of the period for which the person has made required payments.

4) The day the person becomes covered (after the day the person made the election for continuation coverage) under any other group health plan, on an insured or uninsured basis. This item (4) by itself will not prevent coverage from being continued until the end of any period for which pre-existing conditions are excluded or benefits for them are limited under the other health plan.

5) The day the person becomes entitled to Medicare benefits.

6) The day the Employer no longer provides group health coverage to any of its Employees.

California Continuation Coverage

Employees entitled to COBRA continuation coverage due to employment termination on or after January 1, 1996 are entitled to extend medical coverage for themselves and their spouses after their initial 18-month COBRA period ends, provided the Employee was at least age 60 on the date employment ended, had worked for the University for at least five continuous years immediately prior to termination, and was eligible for and elected COBRA continuation medical plan coverage in connection with the termination of employment. The former spouse of the above former Employee is entitled to California Continuation Coverage, provided the former spouse continued coverage under COBRA as a Qualified Beneficiary. This continuation does not apply to children of a former Employee. The continuation will end on the earlier of:

a) The date the individual turns 65;

b) The date the University no longer maintains the group plan, including any replacement plan;

c) The date the individual is covered by a group medical plan not maintained by the University;

d) The date the individual becomes entitled to Medicare; or

e) With respect to the spouse or former spouse only, the date five years from the date COBRA ends for the spouse or former spouse.

If the Employee's coverage terminates, the spouse may continue coverage until one of the terminating events applies to the spouse. WHA will notify eligible COBRA Qualified Beneficiaries before the end of the maximum eighteen month COBRA continuation period. If an eligible individual wishes to continue the coverage they must apply, in writing, to the medical carrier no later than 30 days before the end of the COBRA continuation period.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is comprehensive federal legislation which provides, among other things, portability of health care coverage for individuals changing jobs or who otherwise lose their group health care coverage. To protect individuals who lose coverage, including a job change or selection of a new health plan, HIPAA restricts the use of preexisting condition limitations. Individuals who lose coverage must choose COBRA coverage or individual continuation and pay for this coverage the entire time it is offered in order to qualify as an "eligible individual" under HIPAA. WHA will automatically provide certificates of coverage for subscribers and dependents that lose coverage.

If subscribers or dependents have questions concerning HIPAA, they may contact HCFA at (415) 744-3600 or at the following Internet address:

http://www.hcfa.gov/regs/hipaacer.htm

To the extent that the provisions of the group agreement and Combined Evidence of Coverage and Disclosure Form do not comply with any provision of the Health Insurance Portability and Accountability Act of 1996, they are hereby amended to comply.

Cost of Continuation Coverage

The cost of the coverage will include any portion previously paid by the Employer and shall not be more than 102% of the applicable group rate during the period of basic COBRA coverage; or not more than 150% any time during the 11-month disability extension

period (i.e., during the 19th through the 29th months); or not more than 213% during the extension period allowed by California Continuation Coverage.

For information on Open Enrollment actions for which a Qualified Beneficiary may be eligible and/or any applicable plan modifications and premium adjustments, contact University of California Human Resources and Benefits at (800) 888-8267 during the month of November.

Please Note: When your continuation coverage ends, you may be able to convert your coverage to an Individual Conversion plan if you wish.

Individual Conversion Option

When a Member's coverage ends because of retirement, termination of employment, end of the continued group coverage period or loss of eligibility, it may be converted to an individual conversion plan. The benefits and cost differ from those of this Plan. A statement of health is not required. You must apply for conversion within 31 days of the date the group (including COBRA continuation) coverage ends.

Renewal Provisions

Annual renewal is automatic provided that you seek to renew coverage under the same group agreement and all premiums have been properly paid. Premiums may change upon renewal. If your or your dependents' coverage is terminated, you must submit a new application in order to be reinstated.

Ineligibility

If you were previously a Member of WHA and your coverage was canceled for any of the reasons listed under the "Reasons for Termination" section below, you are not eligible to enroll.

Termination of Benefits

If your WHA coverage is terminated for any of the reasons discussed in this section, you will be notified in writing of the reason for cancellation and the grievance process for appeals. Since you will remain a WHA Member until your termination date, any medically necessary services will continue to be provided in accordance with this Combined Evidence of Coverage and Disclosure Form. Your rights to benefits end as of your coverage termination date. Refer to the "Exception to Cancellation of Group Benefits" section for a list of exceptions to cancellation of coverage.

Reasons for Termination

Once you are enrolled in WHA, your coverage cannot be canceled because of health conditions; coverage can be terminated only for the reasons specified in the Group Agreement. If your Membership is terminated for any of the following reasons, your coverage ends on the termination date.

- Prepayment fees are not received within the specified grace period. Termination is effective on the last day of the period for which appropriate fees were received.
- Required Copayments are not made for services received.
- You have been unable to establish a satisfactory relationship with your Primary Care Physician. You will be given a reasonable opportunity to establish an effective patient/Physician relationship before coverage is terminated.
- Incorrect or misleading information is provided. Termination is retroactive to the date the information was given or omitted.
- You knowingly use an invalid ID card or allow someone else to use your card. The WHA ID card is only valid for the Member named on it. Termination is retroactive to the date of card misuse.
- The Member refuses to follow recommended medical treatments or procedures where the physician believes there are no alternatives of professionally recognized standards of care that are acceptable to the Member. (You may seek a second opinion from another Participating Provider.)
- Seeking and/or obtaining medications under false pretenses to support a drug dependency or for the illegal sale of the medications.
- Materially threatening, disruptive or illegal behavior toward a WHA provider or employee.
- Frequently missed or canceled appointments with less than 24 hours notice. You will be given a reasonable opportunity to correct this problem before it leads to cancellation.
- If a Subscriber no longer works or maintains a permanent residence within the Service Area, coverage will be terminated for the Subscriber and any enrolled Dependents effective midnight of the last day of the month in which such event occurred. However, coverage may be continued for a Subscriber and any enrolled Dependents if the Subscriber is temporarily assigned by the Employer to work or study outside of the Service Area. The

subscriber must maintain a permanent residence within the Service Area and that the temporary residency outside the Service Area must not continue beyond 2 months. Coverage may also be continued for any Eligible Dependent who is a registered, full-time student at an accredited college or university outside the Service Area as long as the Subscriber either works or maintains a permanent residence within the Service Area and the Eligible Dependent qualifies as the Subscriber's dependent under Internal Revenue Service standards. (See Student Brochure). If you need a copy of the Student Brochure, contact Member Services at (916) 563-2251 or (888) 563-2251.) In such cases, coverage for services received outside the Service Area shall be limited to Urgent Care and Emergency Care.

All non-Urgent Care and non-Emergency Care services must be provided by Participating Providers within the service area in order to be covered under this health Plan.

- If a Subscriber or Member makes a false statement, misrepresentation, or omission, in the application and enrollment forms, a response to a subordination request from WHA, or any other correspondence or communication with WHA, including but not limited to statements, misrepresentations or omissions regarding a Member's health history or a Member's eligibility for Membership; or obtains or attempts to obtain Covered Services by means of false statements, misrepresentations or omissions; or permits any other person to use the Member's identification card to obtain services under this health plan or otherwise misuses the Member's identification card; or if the Member engages in any other fraudulent conduct, WHA may terminate coverage to be effective upon the mailing of written notice by the Plan to the Employee/Annuitant and the University.

Please note that coverage may also be terminated by giving written notice that you wish to disenroll.

You are responsible for notifying any Family Members that coverage has been canceled.

Fraud

Coverage for an Employee/Annuitant or covered Dependent may be terminated for fraud or deception in the use of the services of the Plan, or for knowingly permitting such fraud or deception by another. Deception includes but is not limited to intentionally enrolling an ineligible individual. Such termination shall be effective upon the mailing of written notice by the Plan to the Employee/Annuitant and the University. A dependent that commits fraud or deception will be permanently disenrolled while any other dependent and the Employee/Annuitant will be disenrolled for 18 months. If an Employee/Annuitant commits fraud or deception, the Employee/Annuitant and any dependents will be disenrolled for 18 months.

Termination of Group Agreement

Your Employer may terminate coverage with a written notice of cancellation to WHA. Coverage for all enrolled Members of the group will end if the Group Agreement is terminated for any reason or if WHA terminates the agreement because of nonpayment of charges or misrepresentation. Benefits cease on the date the agreement terminates.

Exception to Cancellation of Group Benefits

WHA does not cover any services or supplies provided after termination of the agreement or after any Member's coverage terminates. Coverage will cease regardless of whether a course of treatment or condition commenced while coverage was in effect. Exceptions are provisions for group continuation (COBRA) coverage and the following circumstances:

- You or any of your enrolled Dependents are a registered bed patient in a hospital at the date of termination. You or your Dependent will continue to receive all benefits of coverage for the condition confining you to the hospital, subject to the prepayment fees and applicable Copayments until those benefits expire or you are discharged from the hospital, whichever occurs first.

- You or any of your enrolled Family Members are receiving inpatient obstetrical care at the date of termination and there has been no default in prepayment fees. Inpatient obstetrical care will continue only through discharge.

- Total disability by a condition for which you are receiving covered benefits. WHA will continue to maintain coverage for the disabling condition only. Coverage will end (1) at the close of the 12th month following termination, (2) when it is determined you are no longer disabled, or (3) the disabled person is covered under a replacement agreement or policy without limitations as to the disability condition, whichever occurs first.

Effective Date of Termination of Coverage

Coverage as a Member of a group ceases on the earliest of the following dates:

- The last day of the last pay period for which a premium is paid based on earnings as an eligible Employee;
- The last day of the last pay period in which the Employee has an eligible appointment;
- The last day of the second month following the month in which the Employee last meets the minimum required average regular paid time;
- The last day of the last pay period the individual is eligible for coverage as a Dependent or is eligible for continued group coverage;
- The last day of the month in which a form to cancel/opt out of coverage or delete a Dependent is received in the local Benefits or Accounting Office;
- The last day of the last month for which a premium was paid while the Employee's application for disability income was pending; or
- The day the Group Agreement between the University and WHA is terminated.

Employees/Annuitants may cancel medical plan coverage or delete a Dependent from the Plan at any time by submitting the appropriate forms to their local Benefits Office or complete the appropriate electronic transaction. However, an Annuitant's Plan coverage must be continuous. **Once Medical Plan coverage as an Annuitant is cancelled, coverage cannot be reinstated.**

Refunds and Review of Termination

If your coverage terminates, payment of premiums for any period after the termination date and any other amounts due to you will be refunded to your Employer within 30 days, minus any amount due to WHA. Exceptions include termination by WHA for fraud or deception in the use of health services or facilities or knowingly permitting such fraud or deception by another. If you believe your Membership was terminated improperly by WHA, you may request a review of the termination by the California Commissioner of Managed Healthcare.

FINANCIAL CONSIDERATIONS

Prepayment Fees

Your Employer is responsible for prepayment of monthly premiums for WHA coverage. You will be notified by your Employer if you are required to pay a portion of these premiums.

Other Charges - Copayments

You are responsible for fees (Copayments) paid to providers at the time the service is rendered. See the "Covered Services Summary" section for specified Copayments.

Reimbursement Provisions

If, in an Emergency, you have to use non-participating hospitals or Physicians, WHA will reimburse you for charges or will arrange to pay the providers directly, minus applicable Copayments. Requests must be submitted for reimbursement within 180 days of the date services were rendered and proof of payment enclosed.

Maximum Copayment Liability

Maximum Copayment liability for Members under this Plan, per calendar year, is limited to $750 for an individual and $1,500 for a family.

All Copayments, except for prescription medication Copayments, are applied to the Maximum Copayment Liability.

Members are responsible for keeping all Copayment receipts and submitting these receipts to WHA as verification that the maximum Copayment liability has been reached for that calendar year.

Limitation on Benefits

Coordination of Benefits

Coordination of benefits is a method used by insurance companies, health maintenance organizations and regulatory agencies to preclude duplicate payment of the same claims when more than one plan covers a Member.

WHA includes a coordination of benefits provision in all agreements in order to provide Members with broad protection at the lowest possible cost. This provision establishes the rules by which WHA and other plans will determine the order of payment of claims, while providing that the Member does not receive more than 100% coverage from all plans and insurers combined. You have a contractual obligation as a WHA Member to cooperate and assist with WHA's coordination of benefits by providing information to all health service providers on any other coverage you or your Dependents have. The agreement outlines when WHA or another carrier is the primary payor. Duplicate

coverage does not reduce your obligation to make all required Copayments in any way.

Third Party Responsibility - Subrogation

In cases of injuries caused by any act or omission of a third party (including, without limitation, motor vehicle accidents and Workers' Compensation cases), WHA will furnish Covered Services. However, in the event of any recovery from a third party on account of such injuries, the Member will reimburse WHA for the value of the services and benefits, as set forth below. By enrolling in this Plan, each member grants WHA a lien on any such recovery and agrees to protect the interests of WHA when there is possibility that a third party may be liable for a Member's injuries. Each Member specifically agrees as follows:

a) Each Member will give prompt notification to WHA of the name and location of the third party, if known, and of the circumstances which caused the injuries; and

b) Each Member will execute and deliver to WHA or its nominee any and all lien authorizations, assignments or other documents requested by WHA which may be necessary or appropriate to protect the legal rights of WHA or its nominee fully and completely.

This reimbursement will not exceed the total amount of recovery you obtain. The Member may not take any action that might prejudice WHA's subrogation rights.

If you receive a judgment or settle a claim for injury and the judgment or settlement does not specifically include payment for medical costs, WHA will nevertheless have a lien against such recovery for the value of the Covered Services and benefits at prevailing rates.

When a member fails to cooperate in satisfying WHA's subrogation interest, and WHA must file a lawsuit against the Member or the third party in order to enforce its rights under this provision, the Member or any Dependent of his or hers receiving benefits under this Plan will be responsible for attorneys' fees and costs incurred by WHA.

Non-Duplication of Benefits

WHA does not duplicate any benefits to which Members are entitled under workers' compensation law, employer liability laws, Medicare Part A and B, or CHAMPUS. WHA retains all sums payable under these laws for services provided. By your enrollment, you agree to submit the necessary documents requested by WHA to assist in recovering the maximum value of services you receive under Medicare, CHAMPUS, the workers' compensation law, or any other health plans or insurance policies.

If you fail to submit documents reasonably requested by WHA, you must pay for services received at prevailing rates. Duplicate coverage does not reduce your obligation to make all required Copayments.

Extension of Benefits

WHA does not cover a disabling condition that is being covered under an extension of benefits provision of another medical plan.

Other Limitations On Coverage

Limitations on your coverage may apply in the event of major disasters, epidemics, labor disputes and other circumstances beyond WHA's control. Please consult the Group Agreement for further information on these limitations.

PLAN ADMINISTRATION

By authority of The Regents, University of California Human Resources and Benefits, located in Oakland, California, administers this Plan in accordance with applicable Plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts/service agreements, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by The Regents. The terms of those documents apply if information in this booklet is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of this booklet and/or the Group Agreement. What is written in this booklet does not constitute a guarantee of plan coverage or benefits -- particular rules and eligibility requirements must be met before benefits can be received. Health and welfare benefits are subject to legislative appropriation and are not accrued or vested benefit entitlements.

This section describes how the Plan is administered and explains your rights.

Sponsorship and Administration of the Plan

The University of California is the Plan sponsor and administrator for the Plan described in this booklet.

If you have a question, you may direct it to:

University of California
Human Resources and Benefits
300 Lakeside Drive, 5th Floor
Oakland, CA 94612-3557
(800) 888-8267

Claims under the Plan are processed by Western Health Advantage at the following address and phone number:

Western Health Advantage
Attn. Claims Department
1331 Garden Highway, Suite 100
Sacramento, CA 95833-9773
(916) 563-2251 or (888) 563-2251

Group Contract Number

The Group Number for this Plan is: **00-1021**.

Type of Plan

This Plan is a health and welfare plan that provides group medical care benefits. This Plan is one of the benefits offered under the University of California's employee health and welfare benefits program.

Plan Year

The plan year is January 1 through December 31.

Continuation of the Plan

The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. The Plan is not a vested plan. The right to terminate or amend applies to all Employees, Annuitants and Plan Beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, premiums and what portion of the premiums the University will pay. The portion of the premium the University pays is subject to state appropriation, which may change or be discontinued in the future.

Financial Arrangements

The benefits under the Plan are provided by Western Health Advantage under a Group Agreement.

Agent for Serving of Legal Process

Legal Process may be served on Western Health Advantage at the following address:

Western Health Advantage
Attn. Claims Department
1331 Garden Highway, Suite 100
Sacramento, CA 95833-9773
(916) 563-2251 or (888) 563-2251

Your Rights under the Plan

As a participant in a University of California medical plan, you are entitled to certain rights and protections. All Plan participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, or instead of or in addition to, at other locations that may be specified by the Plan Administrator, all Plan documents, including the Group Agreement.

Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

Claims under the Plan

If Urgent Care or Emergency services were received outside of the WHA Service Area, and the Member incurred such expenses, the Member must submit an itemized bill, the Member's identification number and a copy of the paid receipt to WHA in order to be reimbursed. Request must be submitted for reimbursement within 180 days for the date services were rendered.

Request for reimbursement should be sent to:

Western Health Advantage
Attn. Claims Department
1331 Garden Highway, Suite 100
Sacramento, CA 95833-9773
(916) 563-2251 or (888) 563-2251

If the request for reimbursement is denied, the Member may file an appeal through the Member Satisfaction Procedure.

Nondiscrimination Statement

In conformance with applicable law and University policy, the University of California is an affirmative action/equal opportunity Employer.

Inquiries regarding the University's affirmative action and equal opportunity policies may be directed to Executive Director Sheila O'Rourke (for academic employee-related matters) or to Mattie L. Williams (for staff employee-related matters); both at this address:

University of California
Office of the President
1111 Franklin Street
Oakland, CA 94607

MEMBER SATISFACTION PROCEDURE

WHA strives to provide exceptional health care services to you. However, if you should have a concern about your medical care, you should discuss it with your Primary Care Physician. If you need help answering your questions, clarifying procedures or investigating complaints, call Member Services between 8 a.m. and 5 p.m. Monday through Friday, at (916) 563-2250 / (888) 563-2250. If you prefer, you can visit or write to:

Western Health Advantage
Member Services Department
Attention: Appeals and Grievance Coordinator
1331 Garden Highway, Suite 100
Sacramento, CA 95833

A Member Services representative will research and respond to your questions. If you are not satisfied with the response or action taken, you may pursue a formal appeal or grievance.

Appeal and Grievance Procedure

If you have a complaint with regard to WHA's failure to authorize, provide or pay for a service that you believe is covered, or any other complaint, please call Member Services for assistance. If your complaint is not resolved to your satisfaction after working with a Member Services representative, a verbal or written appeal or grievance may be submitted to:

Western Health Advantage
1331 Garden Highway, Suite 100
Sacramento, CA 95833
Attn: Appeals Department
1-888-563-2251

Please include a complete discussion of your questions or situation and your reasons for dissatisfaction and submit the appeal or grievance to WHA Member Services within 30 days of the initial determination, or denial of a service. If you are unable to meet this time frame, please contact Member Services on how to proceed.

WHA sends an acknowledgment letter to the Member within five (5) working days of receipt of the request for an appeal. If the complaint involves a quality of care issue or involves medical decision-making, it is reviewed by WHA Medical Management, under the direction of the Chief Medical Officer. A determination is rendered within thirty (30) calendar days of receipt of the Member's request for an appeal. WHA will notify the Member of the determination, in writing, within three (3) working days of the decision being rendered.

A Complaint Form is available and you may request one by calling Member Services. If you would like assistance in filing a complaint or an appeal, please call Member Services and a representative will assist you in completing the Complaint Form or explain how to write your letter. We will also, be happy to take the information over the phone verbally.

It is the policy of WHA to resolve all appeals and/or grievances within 30 days of receipt. However, if more time is required due to the complexity of the issue, or there is a delay due to circumstances beyond WHA's control, you will be notified in writing. The written notification will be sent to the Member for a fifteen (15) working day extension. The written notification will be sent within thirty (30) working days and will include an explanation of the cause of the delay. Contact Member Services for more detailed information about the appeals and grievance procedure.

The California Department of Managed Care is responsible for regulating health care service plans. The department has a toll-free telephone number (800-400-0815) or (888) HMO-2219 to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers (877) 688-9891 (TDD) to contact the department. The department's Internet website http://www.dmhc.ca.gov has complaint forms and instructions online. Should you have an appeal or grievance against the health plan, you should contact the Plan and use the Plan's grievance process. If you need the Department's help with a complaint involving an Emergency grievance or with a grievance that has not been satisfactorily resolved by the Plan, you may call the California Department of Managed Care's toll-free telephone number.

Expedited Appeal Review

An expedited appeal is a request by the member or a practitioner on behalf of a member or a representative for the member requesting reconsideration of a denial of services that requires a review and determination be completed within 72-hours as the treatment requested may be an imminent and a serious threat to the health of the Member, including but not limited to potential loss of life, limb, or major bodily function.

The expedited appeal process is initiated upon receipt of a letter, fax, and/or verbal in person or telephonic request from the member, practitioner on behalf of the member or a person representing the member. The request is logged and all necessary information is collected in order to review and render a decision. If it is determined that a delay of the requested review would compromise the member's life or health, the appeal is then reviewed under expedited conditions.

After an appropriate clinical peer reviewer has reviewed all of the information a decision is rendered. The decision is then communicated verbally via telephone to the member and practitioner no later than 72-hours after the review began. A letter documenting the decision, whether it is to overturn the original denial or to uphold the original denial, is sent to the practitioner with a copy to the member within two working days of the decision. The letter contains all clinical rational used in making the decision.

Appeal for Investigational/Experimental Treatment

WHA excludes from coverage services, medication or procedures, which are considered investigational and/or experimental treatment and which are not accepted as standard medical practice for the treatment of a condition or illness.

If a specific procedure is requested, and after careful review by the appropriate medical personnel, the Plan's determination is that the therapy is experimental or investigational and, therefore, not a covered benefit, the member will be notified of the denial in writing within five (5) business days of the decision.

If a member with a terminal illness disagrees with the denial of a service, medication, device or procedure deemed to be experimental, they may request a review by outside medical experts. This request can be made verbally or in writing. The member may also request a face-to-face meeting with WHA's Chief Medical Officer to discuss the case.

WHA will gather all medical records and necessary documentation relevant to the patient's condition and will forward all information to an external independent reviewer within five (5) days from the date of the request.

If the member has a life threatening or severely debilitating condition and it is determined by a physician that the member is likely to die within two years, or their health or ability to function could be seriously harmed by waiting the usual 30 business days for review, an expedited review may be requested, in which case a decision will be rendered within seven (7) business days. The appeal request may be a verbal or written. The written request is to be submitted to:

Western Health Advantage
1331 Garden Highway, Suite 100
Sacramento, CA 95833
Attn: Appeals Department
1-888-563-2250

The Member's physician certifies that the Member has a terminal condition for which standard therapies are or have not been effective in improving the Member's condition, or would not be medically appropriate for the Member, or there is no more beneficial standard therapy covered by WHA than the therapy recommended pursuant the following:

a. Either the Member's physician, contracted with WHA, has recommended treatment that he/she certifies in writing is likely to be more beneficial to the Member than any available standard therapies, or

b. The Member, or his/her physician who is a licensed, board-certified or board-eligible physician not contracted with WHA, but qualified to practice in the specialty appropriate to treat the Member's condition, has requested a therapy that, based on two documents from the medical and scientific evidence is likely to be more beneficial for the Member than any available standard therapy. The physician's certification must include a statement of evidence relied upon by the physician in certifying his/her recommendation.

Note: WHA is not financially responsible for payment to non-contracted providers that are not prior authorized.

If a member with a life threatening or severely debilitating condition disagrees with the denial of a service, medication, device or procedure deemed to be experimental, who meet the criteria above, they may request a review by outside medical experts. This request can be made verbally or in writing. The member may also request a face-to-face meeting with WHA's Chief Medical Officer to discuss the case. WHA will gather all medical records and necessary documentation relevant to the patient's condition and

will forward all information to an external independent reviewer within five (5) days from the date of the request.

If the member does not have a life threatening or severely debilitating condition or their health or ability to function will not be seriously harmed by waiting, the decision will be rendered within 30 business days. The independent expert may request the deadline be extended by up to three (3) days for a delay in receiving all of the necessary documentation from WHA, the member and/or the physician.

Binding Arbitration

The final process for resolving a dispute is arbitration. If you continue to be dissatisfied with the results of the appeals and grievance process and wish to pursue the matter further, you must submit your claim or controversy to binding arbitration within 60 days of completion of the appeals and grievance process. The arbitration procedure is governed by the American Arbitration Association rules. Copies of these rules and other forms and information about arbitration are available by calling the American Arbitration Association at (415) 981-3901 or by contacting Member Services.

All interested parties, including Members, specifically agree to use WHA's arbitration procedure in place of any rights they otherwise would have to submit any controversy or dispute to a court or jury. For a complete description of how to initiate arbitration, please refer to the agreement.

DEFINITIONS

"**Appeal**" is a formal request either verbal or written by a practitioner or member for reconsideration of a decision, such as a utilization review recommendation, a benefit payment, an administrative action, or a quality-of-care or service issue, with the goal of finding a mutually acceptable solution.

"Approved Drug Usage" means (1) use for the labeled indications (FDA-approved indications) or (2) use by a Physician for treatment of a life-threatening condition for which the drug has been recognized by the AMA Drug Evaluations, the American Hospital Formulary, the United States Pharmacopoeia, or at least two articles from major peer reviewed medical journals that present data supporting the proposed use as safe and effective unless clear and convincing contradictory evidence appears in a similar journal.

"Charges" means the Participating Providers' contracted rates or the actual charges payable for Covered Services, whichever is less. Actual charges payable to non-Participating Providers shall not exceed usual, customary and reasonable charges as determined by WHA.

"Copayment" means a fee charged to a Member, which is approved by the Department of Managed Care of the State of California, provided for in the Group Agreement and disclosed in this Combined Evidence of Coverage and Disclosure Form (See the "Covered Services Summary" section). Percentage Copayments are based on negotiated rates for service. Within 60 days after the end of any contract year, a Subscriber may apply to WHA for a refund of the excess of the Maximum Copayment Liability paid over the contract year by submitting receipts as verification.

"Covered Services" means those Medically Necessary health care services and supplies which a Member is entitled to receive, as defined solely by WHA and which are described in the "Principal Benefits and Coverages" section and not excluded or limited by the "Principal Exclusions or Limitations" section of this Combined Evidence of Coverage and Disclosure Form.

"Crisis Intervention" means treatment directed toward alleviation of an acute psychiatric condition, or of the exacerbation of a pre-existing psychiatric condition, by short-term intensive therapy to reduce impairment or disability.

"Custodial" or "Domiciliary Care" means care which can be provided by a layperson, which does not require the continuing attention of trained medical or paramedical personnel, and which has no significant relation to treatment of a medical condition.

"Dental Services" means any services or X-ray exams involving one or more teeth, the tissue or structure around them, the alveolar process or the gums. Such services are considered dental even if a condition requiring any of these services involves a part of the body other than the mouth, such as treatment of Temporomandibular Joint Disorders (TMJD) or malocclusion involving joints or muscles by such methods as crowning, wiring or repositioning teeth.

"Durable Medical Equipment" means Medically Necessary standard equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, and generally is not useful to a person in the absence of an illness or injury.

"Educational Services" means services or supplies whose primary purpose is to provide any of the following: training in the activities of daily living; instruction in scholastic skills such as reading or writing; preparation for an occupation; or treatment for learning disabilities.

"Emergency" medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, with an average knowledge of health and medicine could reasonably expect in the absence of immediate medical attention to result in:

- Serious danger to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious damage to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services and Care also pertain to:

- Psychiatric screening, examination, evaluation, and treatment by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and privileges.
- Care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition within the capability of a facility.

WHA will make all final determinations about Emergency care.

"Experimental" or "Investigational Procedures" means services, tests, treatments, supplies, devices or drugs which WHA determines are not accepted as standard medical practice by informed medical professionals in the United States, at the time the services, tests, treatments, supplies, devices or drugs are rendered, as safe and effective in treating or diagnosing the condition for which their use is proposed, unless approved by:

a) The Diagnostic and Therapeutic Technology Assessment Project of the American Medical Association;

b) The Center of Healthcare Technology;

c) The National Institute of Health;

d) The Federal Food and Drug Administration;

e) The specialty board and the academy it represents as recognized by the American Board of Medical Specialties (ABMS) or

f) An external Independent Review expert hired to review all appeals for investigational/experimental treatments.

"FDA-Approved Drug" means drugs, medications and biologicals approved by the Food and Drug Administration and listed in the United States Pharmacopoeia, the AMA Drug Evaluations and/or the American Hospital Formulary.

"Grievance" means a written Complaint or dissatisfaction about a Member or Provider's experience with WHA, a Medical Group and/or any WHA providers.

"Group Agreement" means the Group Medical and Hospital Service Agreement between your employer and WHA.

"Hospice" means a public agency or private organization that is a Participating Provider and is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

"Hospice Care" means services provided by Participating Providers to Members who are certified by a Participating Physician to be terminally ill (i.e. the Member's medical prognosis is that the life expectancy is six months or less), emphasizing supportive services and dietary counseling under the direction of a Participating Physician and in accordance with a written plan of care.

"Hospital Services" means all Inpatient and Outpatient Hospital Services as herein defined.

"Inpatient Hospital Services" means those Covered Services, which are provided on an inpatient basis by a hospital, excluding long term non-acute care.

"Life threatening" means either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention or treatment is survival.

"Medical Director" means a Physician employed by or under contract with WHA having the responsibility for implementing WHA's utilization management system and quality of care review system. The Medical Director is the Physician who determines appropriate Prior Authorization of Covered Services.

"Medical Group" means a group of Physicians who have entered into a written agreement with WHA to provide or arrange for the provision of Medical Services and to whom a Member is assigned for purposes of primary medical management.

"Medical Services" means those professional services of Physicians and other health care professionals, including medical, surgical, diagnostic, therapeutic and preventive services which are included in the "Principal Benefits and Covered Services" section and which are performed, prescribed or directed by a Primary Care Physician or Specialist Physician.

"Medically Necessary" means that which WHA determines:

- is appropriate and necessary for the diagnosis or treatment of the Member's medical condition, in accordance with professionally recognized standards of care;
- is not mainly for the convenience of Member or Member's Physician or other provider; and
- is the most appropriate supply or level of service for the injury or illness.

For hospital admissions, this means that acute care as an inpatient is necessary due to the kind of services the Member is receiving, and that safe and adequate care cannot be received as an outpatient or in a less intensive medical setting.

"Medicare" is the name commonly used to describe Health Insurance Benefits for the Aged and Disabled provided under Public Law 89-97 as amended to date or as later amended.

"Member" means a Subscriber or Family Member who is entitled to receive Covered Services.

"Mental Conditions" means disturbances or disorders of mental, emotional, or behavioral functioning that are severe enough to disrupt substantially the normal family, social, or work interactions, including the physical symptoms of such disorders, regardless of cause or origin. *(1) severe mental illness, including, but not limited to: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa and bulimia nervosa; and (2) the serious emotional disturbances of children on the same terms and conditions applied to other medical conditions. Serious emotional disturbances of a child are specifically defined as a child suffering from one or more disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders and the child meets the criteria of Welfare and Institutions Code section 5600.3(a)(2).*

Examples of Mental Conditions include, without limitation: stress disorders or ailments, bipolar affective disorder (manic depressive syndrome), schizophrenia, delusional (paranoid) disorders, psychotic disorders, depressive disorders, anxiety disorders, somatoform disorders (psychosomatic illness), eating disorders, and mental illness. The following types of illnesses are excluded from this definition: Alzheimer's disease, multiple sclerosis, amytrophic lateral sclerosis, traumatic brain injuries and demonstrable structural brain damage. Conditions related to drug or alcohol dependence are not included under the mental health care benefits but are treated separately.

"Monthly Premiums" means the prepayment fees paid by or on behalf of Members in order to be entitled to receive Covered Services.

"Open Enrollment Period" means a period established by the University, during which eligible persons who are not currently enrolled in WHA may do so without submitting proof of insurability.

"Orthotic Device" means a rigid or semi-rigid device used as a support or brace affixed to the body externally to support or correct a defect or function of an injured or diseased body part and which is Medically Necessary to the medical recovery of the Member.

"Outpatient Hospital Services" means those Covered Services, which are, provided by a hospital to Members who are not inpatients at the time such services are rendered.

"Participating Hospital" means a duly licensed hospital which, at the time care is provided to a Member, has a contract in effect with WHA to provide Hospital Services to Members. The Covered Services, which some Participating Hospitals may provide to Members, are limited by WHA's utilization review and quality assurance policies or WHA's contract with the hospital.

"Participating Physician" means a Physician whom, at the time care is provided to a Member, has a contract in effect with WHA to provide Medical Services to Members.

"Participating Provider" means a Participating Physician, Participating Hospital, or other licensed health professional or licensed health facility who, or which, at the time care is provided to a Member, has a contract in effect with WHA to provide Covered Services to Members. Information about Participating Providers may be obtained by telephoning WHA at (916) 563-2251 or (888) 563-2251.

"Period of Initial Eligibility (PIE)" means a period during which a Subscriber or Eligible Dependent may enroll without furnishing proof of insurability. The PIE begins the day the Subscriber or Eligible Dependent becomes eligible and ends 31 calendar days from the first date of eligibility (or the preceding business day if the 31st day is on a weekend or a holiday).

"Physician" means a duly licensed doctor of medicine or osteopathy who has entered into a written agreement with WHA or a Medical Group to provide Medical Services to Members.

"Primary Care Physician" means a Participating Physician who:

- Practices in the area of family practice, internal medicine, pediatrics, general practice, or obstetrics/gynecology; and

- Acts as the coordinator of care, including such responsibilities as supervising continuity of care, record keeping and initiating referrals for Specialist Physicians, for Members who select such Primary Care Physician.

"Prior Authorization" means written approval from the Medical Director before a service or supply is received.

"Prosthetic Device" means an artificial device affixed to the body externally to replace a missing part of the body.

"Provider Reimbursement" means the contractual arrangement between WHA and the Participating Providers with which WHA contracts for the provision of covered benefits on behalf of the Members of WHA. The basic method of provider reimbursement used by WHA is "capitation": a per member per month payment by WHA to its contracted providers. Because WHA is a non- profit Plan, owned and directed by local healthcare systems, there are no bonus schedules or financial incentives in place between WHA and its contracted providers which will artificially restrict or limit the amount of care which is provided under the benefits of this Combined Evidence of Coverage and Disclosure Form.

"Service Area" means the geographic area in which WHA has been authorized by applicable regulatory agencies to provide Covered Services to Members.

"Specialist Physician" means a Physician contracted to provide more specialized health care services.

"Subscriber" means the person whose employment or other status, except for family dependency, is the basis for eligibility, which meets all applicable eligibility requirements.

"Totally Disabled" means that an individual is either confined in a hospital as determined to be Medically Necessary or is unable to engage in any employment or occupation for which the individual is (or becomes) qualified by reason of education, training or experience and is not, in fact, engaged in any employment or occupation for wage or profit.

"Urgent Care" means services that are medically required within a short time frame, usually within 24 hours, in order to prevent a serious deterioration of a Member's health due to an unforeseen illness or injury. Members must contact their Primary Care Physician, whenever possible, before obtaining Urgent Care.

"Vocational Rehabilitation" means evaluation, counseling and placement services designed or intended primarily to assist an injured or disabled individual find appropriate employment.

Western Health Advantage
1331 Garden Highway, Suite 100
Sacramento, CA 95833-9773
Phone: (888) 563-2251
(916) 563-2251
Fax: (916) 563-3182

www.westernhealth.com

WHA 305 Revised 10/00
UC-106A