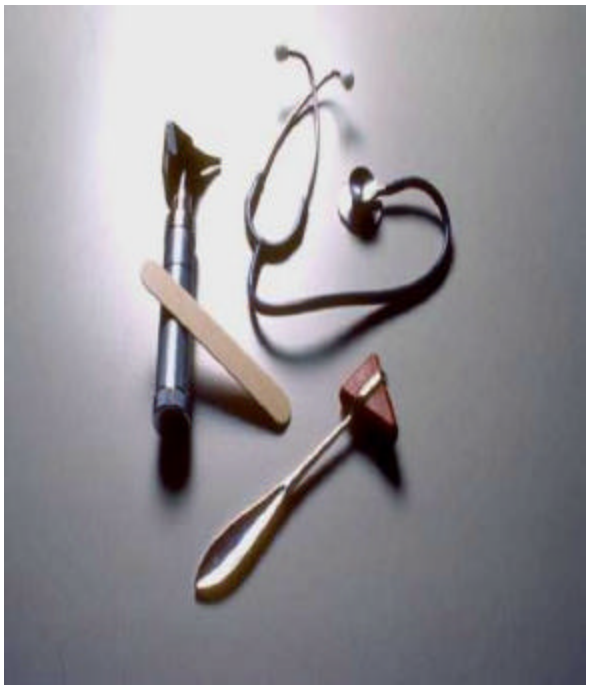
WHA

WESTERN HEALTH ADVANTAGE

University of California

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

2005



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

2005

UC 106A

Group # 00-1021

(For Your Reference)

MEMBER NAME _____

ADDRESS _____

TELEPHONE NUMBER _____

ELIGIBILITY DATE _____

NAME OF PCP _____

PCP'S ADDRESS _____

PHARMACY LOCATION _____

PHARMACY TELEPHONE NUMBER _____

24-HOUR EMERGENCY CARE TELEPHONE NUMBER _____

Changes for 2005

Please make note of the following changes and/or clarifications to your plan effective January 1, 2005.

General changes throughout the booklet:

- **Annuitant** changed to **retiree**
- **Survivor annuitant** changed to **survivor**

Other changes

If you have any questions, please feel free to contact our Member Services Department at (916) 563-2252 or (888) 563-2252, Monday through Friday between 8 a.m. and 5 p.m.

Privacy Notice

Western Health Advantage ("WHA") Notice of Privacy Practices ("Notice")

Notice of Privacy Practices for the Use and Disclosure of Private Health Information (PHI)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WHA is required by law to maintain the privacy of your health information and to provide you this Notice about our legal duties and privacy practices. We must follow the privacy practices described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace or modify it.

Protecting Your Privacy

At WHA, we understand the importance of keeping your health information confidential and we are committed to use your health information consistent with State and Federal law. This Notice explains how we use your health information, and describes how we may share your health information with others involved in your health care. This Notice also lists your rights concerning your health information and how you may exercise those rights.

Protected Health Information (PHI)

For the purposes of this Notice, "health information" or "information" refers to Protected Health Information. Protected Health Information is defined as information that identifies who you are and relates to your past, present, or future physical or mental health or condition, provision of care, or payment for care. The information we use and share includes, but is not limited to:

- your name and address;
- personal information about your circumstances;
- medical care given to you; and
- your medical history.

How We Use Your PHI

WHA uses and shares your health information for the purposes of treatment, payment, health care operations, and other uses permitted or required by Federal, State, or local law. In instances where your health information is not used for such purposes, WHA would require your written authorization prior to sharing it.

Treatment

WHA may use or disclose your health information to health care providers (doctors, hospitals, pharmacies and other caregivers) who request it in connection with your treatment without your written authorization. For example:

- We may share information with physicians, nurses, other health-care professionals, and your medical group or hospital when necessary for you to receive appropriate care and treatment.

Payment

WHA may use and disclose your health information for the purposes of payment of the health care services you receive, without your written authorization. This may include claims payment, eligibility, utilization management, and care management activities. For example:

- We may provide your eligibility information to your medical group so they are paid accurately and timely, or to a third party entity to ensure that your doctor or hospital is paid accurately and timely.
- We may share information about you to a hospital to ensure that claims are billed properly.

Health Care Operations

WHA may use and disclose your PHI in order to administer our health plan. For example, WHA may use and disclose your health information to support various business activities without your written authorization. Health care operations are activities related to the normal business functions of WHA. For example, we may share information with others for any of the following purposes:

- Quality management and improvement activities in order to review and improve the quality of health care services you receive;
- Planning and general administration;
- Research and studies, such as member satisfaction surveys;
- Compliance and regulatory activities;
- Risk management activities;
- Population and disease management studies and programs; and
- Grievance and appeals activities.

Other Permitted Uses and Disclosures

WHA may use or disclose your health information without your written authorization, for the following purposes under limited circumstances:

- To State and Federal agencies that have the legal right to receive data, such as to make sure WHA is making proper payments and to assist Federal/State Medicaid programs. As required otherwise by Federal, State, or local law;
- For public health activities, such as births, deaths, and reporting disease outbreaks or disaster relief. We may provide coroners, medical examiners, and funeral directors information that relates to a person's death;
- For government healthcare oversight activities, such as fraud and abuse investigations or the Food and Drug Administration (FDA);
- For judicial, arbitration, and administrative proceedings, such as in response to a court order, subpoena, or search warrant. For law enforcement purposes, such as providing limited information to locate a missing person;
- To a probate court investigator to determine the need for conservatorship or guardianship;
- For research studies that meet all privacy law requirements, such as research related to the prevention of disease or disability;
- To avoid a serious and imminent threat to health or safety;
- To contact you about new or changed benefits under Medicare and/or WHA;
- To contact you to remind you of visits/deliveries;
- To create a collection of information that can no longer be traced back to you;
- For purposes when issues concern child or elder abuse and neglect;
- For specialized government functions, such as providing information for national security and military activities;
- To Workers' Compensation claims or authorities as required by State Workers' Compensation laws;
- To the Plan Sponsor of a Group Health Plan or employee welfare benefit plan;
- To law enforcement officials if you are an inmate or under custody. These would be permitted if needed to provide medical services to you or for the protection and safety of others; and

- To friends or family members who are assisting you with your health care, with confirmation of that status.

WHA will not use or disclose your PHI for purposes other than those described in this Notice, unless authorized by you in writing. You may revoke this authorization as explained in the section titled "Your Rights Involving Your Health Information."

Sharing Your PHI with Others

As part of normal business, WHA shares your information with contracted Plan Providers (i.e. medical groups, hospitals, pharmacy benefit management companies, social service providers, etc.). In all cases where your PHI is shared with Plan Providers, we have a written contract that contains language designed to protect the privacy of your health information. Our Plan Providers are required to keep your health information confidential, and protect the privacy of your information in accordance with State and Federal law.

Your Rights With Respect to Your PHI

You may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. However, your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

The following are your rights with respect to your health information. If you would like to exercise any of the following rights, please refer to the section below titled, "How to Obtain Additional Information about This Notice."

Right to Request Restrictions

You have the right to ask us to restrict how we use and disclose your information for treatment, payment, or health care operations as described in the Notice. You also have the right to ask us to restrict information that we have been asked to give to family members or to others who are involved in your health care. However, we are not required to agree to these restrictions. If we deny your request, we will notify you in writing with the specific reason(s) the request was denied. If we do agree to your request to restrict health information, we may not use or disclose your PHI for that purpose, except as needed to provide treatment in an Emergency. We also do not have to honor your restriction if we are required by law to disclose the information or when the information is needed for your treatment.

You also have the right to terminate a request for restriction that we have granted. You may do this by calling or writing us. We also have the right to terminate the restriction if you agree to it or if we inform you in writing that we are terminating it. If we do this, it will only apply to medical information that we create or receive after we have informed you.

Your request for a restriction must be in writing and provide us with specific information needed to fulfill your request. This would include the information you wish to be restricted and to whom you want the limits to apply.

Right to Inspect and Copy

You and your personal representative have the right to review or obtain copies of your PHI that may be used to make decisions about you. This includes medical records and billing records. It does not include the following: psychotherapy notes, information to be used in a lawsuit or administrative proceedings, and certain information subject to a law concerning laboratory improvements. Your request must be in writing and provide us with specific information needed to fulfill your request. If you call Member Services at (888) 563-2252 or TDD for the hearing impaired at (888) 877-5378, we will send you a form to use to do this. Or if you prefer, you may send your written request to our

Member Services Department at the address listed in the "Complaints" section of this Notice. If you request copies, we can charge a reasonable fee for the cost of producing the copies and postage. You must pay this fee before we give you the copies. You may also request that we provide you with summary information about your PHI instead of all the information. If so, you must pay us the cost of preparing this summary information before we give it to you.

In certain situations, we may deny your request to inspect or obtain a copy of your PHI. If we deny your request, we will notify you in writing with the specific reason(s) the request was denied. Our letter to you will also include information about how you may request a review of our denial if you are entitled to such a review. You are entitled to request a review of our denial in three instances only. These three instances involve situations where a licensed health care professional has determined that such access would endanger the life or physical safety of you or of another person. Our letter will also tell you about any other rights you have to file a complaint. These are the same rights described in this Notice.

Right to Request an Amendment

You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. Your request should be sent to our Member Services Department at the address listed in the "Complaints" section of this Notice.

We will deny your request if you fail to submit it in writing or if you fail to include the reasons for your request. We may also deny your request if you ask us to amend information that is (1) accurate and complete; (2) not part of our records; (3) not allowed to be disclosed; or (4) not created by WHA.

If we deny your request, we will provide you a written explanation. This letter will tell you how you can file a complaint with us or with the Secretary of the Department of Health and Human Services. It will also tell you about the right you have to file a statement disagreeing with our denial and other rights you may have.

If we accept your request to amend the information, we will make the changes requested in your amendment. But first we will contact you to identify the persons you want notified and to get your approval for us to do so. We will make reasonable efforts to inform others of the amendment and to include the changes in any future disclosures of that information.

Right to Receive Confidential Communications

You have the right to request that we communicate with you in confidence about your PHI by alternative means or to an alternative location (e.g. mail to a post office box address or fax to a designated number, or by phone at a number you give us). Your request must be made in writing and must clearly state that if the request is not granted it could endanger the member. WHA will accommodate reasonable requests.

Right to Receive an Accounting of Disclosures

You and your personal representative have the right to receive an accounting of disclosures regarding your health information. Typically the accounting would include disclosures found in the section titled "Other Permitted Uses and Disclosures" of this Notice. The accounting will not cover those disclosures made for the purposes of treatment, payment, and health care operations, and ones that you have authorized.

All requests for an accounting must be in writing and include specific information needed to fulfill your request. This accounting requirement applies for six years from the date of the disclosure, beginning with disclosures occurring after April 14, 2003, unless you request a lesser period of

time. If you request this accounting more than once in a 12-month period, we may charge you a reasonable fee to produce the accounting of disclosures. Before doing so, we will notify you of the fee, and give you an opportunity to withdraw or limit your request in order to reduce the fee.

******** IMPORTANT ********

WHA DOES NOT HAVE COMPLETE COPIES OF YOUR MEDICAL RECORDS. IF YOU WANT TO LOOK AT, GET A COPY OF, OR CHANGE YOUR MEDICAL RECORDS, PLEASE CONTACT YOUR DOCTOR OR MEDICAL GROUP.

Right to Copies of this Notice

You have the right to receive an additional copy of this Notice at any time. You can also find this notice on our website at: www.westernhealth.com.

How to Complain about Our Privacy Practices

If you believe WHA has violated your privacy rights, or you disagree with a decision we made about access to your health information, you may contact us or the Department of Health and Human Services (DHHS) to make a complaint. We will not retaliate in any way if you choose to file a complaint with us or DHHS. Filing a complaint will not affect your benefits under WHA or Medicare.

Complaints to WHA

If you want to file a complaint with us, you can call or write to:

Western Health Advantage
Attn: Privacy Complaints
1331 Garden Highway, Suite 100
Sacramento, CA 95833
(916) 563-3180

Complaints to the Federal Government

You also have the right to file a complaint with the federal government. You can write to:

Director, Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W. Room 506F
Washington, D.C. 20201

How to Obtain Additional Information about This Notice

If you have any questions about our privacy practices or would like an additional copy of the Notice, please contact Member Services at (888) 563-2252, TTY (888) 877-5378.

Changes to this Notice

The terms of this Notice apply to all records containing your health information that are created or retained by WHA. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to the Notice will be effective for all of your records that we have created or maintained in the past. Such revision or amendment shall also be effective for any of your records that we may create or maintain in the future. If we do revise this Notice you will receive a copy and the new notice will be posted on our website at: www.westernhealth.com.

Questions

If you have any questions about this notice or want further information, please contact us at WHA Privacy Officer, Western Health Advantage, 1331 Garden Highway, Suite 100, Sacramento CA 95833, or call us at (916) 563-2252.

Effective Date of this Notice

This Notice is effective **April 14, 2003** and remains in effect until changed.

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COVERED SERVICES SUMMARY

UC106A

All care and benefits listed are covered when provided or authorized by Western Health Advantage (WHA). This is a Copayment Summary of medical care services; consult the Combined Evidence of Coverage and Disclosure Form for exact benefits, exclusions, limitations and other applicable out-of-pocket expenses.

OUTPATIENT SERVICES **YOU PAY**

Office visits for medical and pediatric care.....$10 per visit
Well-baby care - birth to two years..... Covered in full
Maternity care, after the initial diagnosis,
Pre & post natal..... Covered in full
Surgical Procedures..... $10 per visit
Immunizations (birth to two years)..... ..... Covered in full
(2 and over).....$10 per visit
Periodic physical examinations..... $10 per visit
Office visits for consultation or care by a non-primary provider
when referred by your primary care physician..... $10 per visit
Eye and hearing examinations (all ages) ..... $10 per visit
Laboratory, x-ray, electrocardiograms and
All other tests..... Covered in full
Allergy testing ..... $10 per visit
Therapeutic injections, including allergy shots..... $10 per visit
Family planning services..... $10 per visit
Infertility testing and treatment services, including drugs
provided..... 50% copay

INPATIENT HOSPITALIZATION **$250 PER ADMISSION**

- Semi-private room and board for acute care (private room when determined medically necessary by a participating provider).
- Physicians' services, including surgeons and consultants.
- Hospital specialty services including use of operating and recovery
- room, anesthesia, inpatient drugs, x-ray, laboratory, radiotherapy
- and nursery care for newborn babies.
- Medical, surgical, and cardiac intensive care.
- Private-duty nurse when prescribed by a participating physician.
- Blood transfusion services.

SKILLED NURSING FACILITY

Semi-private room and board in a skilled nursing facility, when medically
necessary and arranged by a primary care physician, including drugs and prescribed ancillary services, up to 100 days maximum
in a calendar year..... Covered in full

REHABILITATION SERVICES

Short-term rehabilitative services including physical therapy, speech therapy, respiratory therapy or an organized program of such services.

Inpatient Rehabilitation..... Covered in full
Outpatient Rehabilitation..... $10 per visit

MAXIMUM COPAYMENT LIABILITY

Maximum Copayment Liability per calendar year is limited to:
Individual..... $1,000
Family..... $3,000

*Copayments for Prescription Medications do not contribute to the Maximum Copayment Liability.

BEHAVIORAL HEALTH & CHEMICAL DEPENDENCY **YOU PAY**

OUTPATIENT – Mental Health

Outpatient services..... $10 per visit

INPATIENT - Mental Health

Inpatient hospital services provided at a participating acute care facility
when authorized in advance by WHA..... $250 per admission

OUTPATIENT – Chemical Dependency

Services for detoxification and for medical conditions associated with substance abuse..... $10 per visit
Rehabilitation services..... $10 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..... $250 per admission

ALL BEHAVIORAL HEALTH SERVICES MUST BE AUTHORIZED BY MAGELLAN BEHAVIORAL HEALTH, INC.

OTHER HEALTH SERVICES

Home health care, when prescribed by a participating physician and determined to be medically necessary ..... Covered in full

Hearing Aids, one standard device per
ear every..... 36 months.50% copay ($2000 benefit maximum)
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

Care provided or authorized in advance by a participating physician at:
Participating physician's office ..... $10 per visit
Participating urgent care facilities..... $10 per visit
Participating hospital emergency room ..... $50 per visit
Non-participating urgent care at an Urgent Care facility ...$50 per visit
Non-participating emergency services ..... $50 per visit
Inpatient care to treat an injury or the sudden onset of an acute illness, including psychiatric illness until your condition permits safe transfer to a participating facility .....$250 per admission

OUTPATIENT PRESCRIPTION MEDICATION*

Retail (30 day supply)
Generic..... $10 copay
Brand Name..... $20 copay
Non-Formulary..... $35 copay

Mail Order (90 day supply)

Generic..... $20 copay
Brand Name..... $40 copay
Non-Formulary..... $70 copay

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 **completely and carefully** 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. An applicant has the right to view The Combined Evidence of Coverage and Disclosure Form prior to enrollment. You may request a copy of the Evidence of Coverage directly from the plan by calling (888) 563-2252, or view the document on the web page: www.westernhealth.com.

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) 563-2252 or (888) 563-2252. 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 (PCP). These providers are conveniently located throughout the WHA Service Area.

All non-Emergency care must be accessed through your PCP, with the exception of obstetrical and gynecological services, which may be obtained through direct access without a referral. Your PCP 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.

Some hospitals and other providers do not provide one or more of the following services that may be covered under your Evidence of Coverage and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; abortion; or transgender services. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call WHA's Member Services Department at (916) 563-2252 to ensure that you can obtain the health care services that you need.

WHA Participating Providers include a wide selection of PCPs, 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*; which at the time it was printed and sent was current; however, this list is updated and reprinted four times a year, so changes may have occurred that could affect your physician choices. If you need another copy of the directory, contact Member Services at (916) 563-2252 or (888) 563-2252 or to view our on-line Provider Directory, WHA's web site address is: www.westernhealth.com.

Liability of Member for Payment

Participating Providers

All non-Urgent Care and non-Emergency Care must be provided by your PCP, his/her on-call physician or a Participating Provider referred by your PCP, with the exception of obstetrical and gynecological services, which may be obtained through direct access without a referral. WHA will not be liable for costs incurred if you seek care from a provider other than your PCP. WHA's contract agreements with Participating Providers state that you, the Member, 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. For services that are not Medically Necessary Covered Services, and the Provider has advised you as such in advance, in writing of such non-coverage and you still agree to receive the services, then you will be financially responsible. (See Provider Reimbursement Definition)

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 medically-necessary Urgent Care and Emergency Care situations.

How to Use Western Health Advantage

Selecting Your Primary Care Physician

When you enroll in WHA, you must select a Primary Care Physician (PCP) for yourself and each of your covered Family Members. Each new Member must select a PCP close enough to his or her home or place of work to allow reasonable access to care. You may designate a different PCP for each Member if you wish. Your PCP 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 PCP or other Participating Provider as referred by your PCP.

If you have never been seen by the PCP you choose, please call his/her office before designating him/her as your PCP. Not only are some practices temporarily closed because they are full, but this also gives the office the opportunity to explain any new patient requirements. The name of your PCP will appear on your WHA identification card. If you do not designate a PCP at the time of enrollment, WHA will assign one for you.

Changing Your Primary Care Physician

Since your PCP coordinates all your covered care, it is important that you are completely satisfied with your relationship with him/her. If you want to choose a different PCP, 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 PCP has been assigned to you, WHA will issue a new ID card confirming the physician's name. 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 PCP, or the services may not be covered.

Transferring to another Primary Care Provider or Medical Group

Any individual Member may change PCP or Medical Groups/IPAs, and transfer from one to another:

1. When the Group's Open Enrollment Period occurs;
2. When the Member moves to a new address (notify WHA in writing within 30 days of the change);
3. When the Member's employment work-site changes (notify WHA in writing within 30 days of the change);
4. When the Member chooses to use the once-a-month transfer option; or
5. When necessary by WHA.

Exceptions

WHA will not allow a once-a-month transfer at the Member's request:

1. If the Member is confined to a Hospital;
2. If the Member is more than three-months pregnant;
3. If the member is in a surgery follow-up period and not yet released by the surgeon; or
4. If the Member is receiving treatment for an acute illness or injury and the treatment is not complete.

NOTE: If you are experiencing one of the above listed exceptions and believe you should be allowed to transfer to another PCP or Medical Group/IPA because of unusual or serious circumstances, please contact WHA's Member Service Department at (916) 563-2252 or (888) 563-2252 and request a review for special consideration to your situation.

Guaranteed Primary Care Access

WHA wants you to receive the care you need when you need it. In most cases, your PCP 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 PCP is not available.

If you have an acute medical need, call your PCP's office and request an immediate appointment. If, for any reason, your PCP's office cannot arrange to see you, call WHA Member Services at (916) 563-2252 or (888) 563-2252 and we will assist you in obtaining a primary care appointment.

Referrals to Specialists

Advantage Referral

In order to expand the choice of specialists, WHA has implemented a unique program, allowing members to access all **specialty physicians within our network that are listed in our directory**, rather than just those who have a direct relationship with your PCP. Your PCP 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. Self-referred, OB/GYN services for women 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. In most cases, you will be comfortable with the specialist that your PCP 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 PCP.

Your PCP will provide a written 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 is sufficient, along with your ID card.

If you have a certain life-threatening, degenerative or disabling condition or disease requiring specialized medical care over a prolonged period of time, including HIV or AIDs, you may be allowed standing referrals, more than one visit, to a specialist or "specialty care center" that has demonstrated expertise in treating the medical condition or disease involving a complicated treatment regimen that requires on-going monitoring. Those specialists designated as having expertise in treating HIV or AIDs are designated in our provider directory under their licensed specialty with an asterisk.

The following services do not require a referral from your PCP:

- On-call Physician Services: The on-call physician for your PCP can provide care in place of your physician.
- Urgent Care: When an Urgent Care situation arises while you are in WHA's Service Area call your PCP, any time of the day, including evenings and weekends. Explain your condition to your doctor or the Physician on-call and they will direct your care. (See Definitions for Urgent Care.)
- Emergency Care: If you are in an emergency situation, please call "911" or go to the nearest hospital emergency room. Notify your PCP the next business day or as soon as possible. (See Definitions for Emergency Care.)
- 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 exam from a Participating Provider does not require a referral.

Prior Authorization

Certain Covered Services require Prior Authorization by WHA in order to be covered. This means that your PCP must contact WHA or in some cases, the participating medical group with which your PCP 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.
- Behavioral health services (except in urgent or emergency situations).

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 lets your provider know 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/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 PCP.

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 PCP. Members may also contact WHA's Member Services Department at (916) 563-2252 or (888) 563-2252 for assistance or for additional information regarding second opinion procedures. Decisions regarding second medical opinions will be authorized or denied 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 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.

If an **Emergency** situation arises whether you are in WHA's Service Area or outside of the Service Area, call "911" immediately or go directly to the nearest hospital Emergency Room. If an **Urgent Care** situation arises while you are in WHA's Service Area, call your PCP. 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 and they will direct your care. In the event you are not able to reach your physician, you may go to an Urgent Care Center affiliated with your medical group.

If you are hospitalized at a non-participating facility because of an Emergency, WHA must be notified within 24 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 and, if possible, arrange for your transfer to a participating hospital as well as make appropriate payment provisions.

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 of the service.

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

Provider Network Adequacy

WHA will ensure the provider network is in sufficient numbers to assure that all covered services are accessible without unreasonable delay, which includes access to emergency services 24 hours a day and seven days per week.

Direct 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.

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 has processes in place, which provide for ongoing authorizations and or referrals to a particular specialist for a chronic or serious medical condition for up to a year at a time, if applicable.

Transition of Care and Continuity of Care

The completion of covered services shall be provided by a terminated provider to an enrollee who at the time of the contract's termination was receiving services from that provider for one of the conditions listed below. The completion of covered services shall be provided by a nonparticipating provider for a newly covered enrollee who, at the time his or her coverage became effective, was receiving services from that provider for one of the conditions listed below:

- An acute condition, for the duration of the acute condition.

- A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health care service plan in consultation with the enrollee and the terminated provider or nonparticipating provider and consistent with good professional practice. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.
- A pregnancy, for the duration of the pregnancy and the immediate postpartum period.
- A terminal illness, for the duration of the terminal illness.
- Care of a newborn child whose age is between birth and age 36 months, for a period not to exceed 12 months.
- Performance of surgery or other procedure that has been authorized by the plan, as part of a documented course of treatment that is to occur within 180 days.

The plan and/or the Medical Group will require the terminated provider whose services are continued beyond the contract termination date to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue the provider's services beyond the contract termination date.

The plan and/or the Medical Group will require a nonparticipating provider whose services are continued pursuant to this section for a newly covered enrollee to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the nonparticipating provider, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the nonparticipating provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue the provider's services.

Unless otherwise agreed by the terminated or the nonparticipating provider and the plan or by the individual provider and the provider group, the services rendered shall be compensated at rates and methods of payment similar to those used by the plan or the provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the terminated provider. Neither the plan nor the provider group is required to continue the services of a terminated provider if the provider does not accept the payment rates as specified here.

If you feel that your medical condition qualifies you under the conditions outlined above, you are entitled to continue your care with the current provider, please contact a WHA representative prior to enrollment, and no later than 30 days from the Effective Date of your WHA coverage. , Please call the Member Service Department, and request for Transition of Care form. Complete and return this form to WHA as soon as possible. Upon receiving the completed form you will be notified if you qualify, and be provided with the plan for your care. If you do not qualify you will be notified in writing and offered alternatives.

In the event your case is outside of the 30 days recommended, individual circumstances will be evaluated by the medical director on a case-by-case basis. To request a copy of our continuity of care

policy, please call our Member Services Department at (888) 563-2252, (916) 563-2252, or from WHA's web page www.westernhealth.com.

Your Contracted Medical Group must preauthorize or coordinate services for continued care. If you have any questions, want to appeal a denial, or would like a copy of WHA's Transition of Care Policy, call our Member Service Department at (916) 563-2252, Monday through Friday, 8 a.m. to 5 p.m.

Please Note: You should not continue care with a non-participating provider without WHA's or your Contracted Medical Group's approval. If you do not receive preauthorization, payment for services performed by a non-participating provider will be your responsibility.

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.

Member Rights & Responsibilities

General Information

WHA's Member Rights and Responsibilities outline not only the Member's rights but also the Member's responsibilities as a Member of WHA. You may request a separate copy of this Member Rights and Responsibilities by contacting our Member Services staff. It is also available on the WHA website www.westernhealth.com.

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

- To be provided information about WHA's services, providers and practitioners, managed care requirements, processes used to measure quality and improve member satisfaction, and your rights and responsibilities as a member.
- To be treated with respect and dignity and recognition of your right to privacy.
- To actively participate with practitioners in making decisions about your healthcare, to the extent permitted by law, including the right to refuse treatment or leave a hospital setting against the advice of the attending physician.
- To expect candid discussion of appropriate, or medically necessary, treatment options regardless of cost or benefit coverage.
- To voice a complaint, or appeal a decision to WHA, about the organization or the care it provides, with the expectation that a process is in place to assure timely resolution of the issue.
- To make recommendations regarding WHA's member rights and responsibilities policies.
- To follow preventive health guidelines, prescribed treatment plans, and guidelines given by those providing health care services and to provide to those professionals information relevant to your care.
- To know the name of the physician who has primary responsibility for coordinating your care and the names and professional relationships of others who may provide services including the practitioner's education, certification or accreditation, licensure status, number of years in practice, and experience performing certain procedures.
- To receive information about your illness, the course of treatment, and prospects for recovery in terms that can be easily understood.
- To receive information about proposed treatments or procedures to the extent necessary for you to make an informed consent to either receive or refuse a course of treatment or procedure. Except in emergencies, this information shall include: a description of the procedure or treatment, medically significant risks associated with it, alternate courses of treatment or non-treatment including the risks involved with each, and the name of the person who will carry out a planned procedure.
- To confidential treatment and privacy of all communications and records pertaining to care you received in any health care setting. Written permission will be obtained before medical records are made available to persons not directly concerned with your care, except as permitted by law or as necessary in the administration of the Health Plan. WHA's policies related to privacy and confidentiality are available to you upon request.
- To full consideration of privacy and confidentiality around your plan for medical care, case discussion, consultation, examination and treatment including the right to be advised of the reason an individual is present while care is being delivered.
- To reasonable continuity of care along with advance knowledge of the time and location of an appointment, as well as, the name of the practitioner scheduled to provide your care.
- To be advised if the physician proposes to engage in, or perform, human experimentation within the course of care or treatment and the ability to refuse to participate in such research projects if

desired.
- To be informed of continuing health care requirements following discharge from a hospital or practitioner's office.
- To examine and receive an explanation of bills for services regardless of the source of payment.
- To have these member rights apply to a person with legal responsibility for making medical care decisions on your behalf. This person may be your physician.
- To have access to your personal medical records.
- To formulate advance directives for health care.

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

- To know, understand, and abide by the terms, conditions, and provisions set forth by WHA as your Health Plan. The Evidence of Coverage (EOC) document you received at the time of enrollment and annually thereafter contain this information.
- To supply WHA and its providers and practitioners (to the extent possible) the information they need to provide care and service to you. This includes informing WHA's Member Service Department when a change in residence occurs or other circumstances arise that may effect entitlement to your coverage or eligibility.
- To select a primary care physician (PCP) who will have primary responsibility for coordination of your care and to establish a relationship with that PCP.
- To learn about your medical condition and health problems and to participate in developing mutually agreed upon treatment goals with your practitioner to the degree possible.
- To follow plans and instructions for care that you have agreed to with your practitioners.
- To schedule appointments, as needed or indicated, to notify the physician when it is necessary to cancel an appointment and to reschedule cancelled appointments if indicated.
- To show consideration and respect to the providers and their staff and to other patients.
- To express grievances regarding WHA, or the care or service received through one of WHA's providers, to the Plan's Member Service Department for investigation through WHA's grievance process.

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

- Upon the request of a member, disclose to consumers factors such as; methods of compensation, ownership of or interest in healthcare facilities, 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 PCP or other Participating Providers to whom you have been referred by your PCP. 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;
- 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)

Cancer Screenings

Includes, but is not limited to, all generally medically accepted cancer screening tests, an annual cervical cancer screening test, including a conventional Pap smear test, and upon referral by the Member's physician, nurse practitioner, or certified nurse midwife, the option of any cervical cancer screening test approved by the Federal Food and Drug Administration; 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.

Cancer Clinical Trials

Routine patient care costs related to the participation of a Member who has been diagnosed with cancer in a clinical trial, if the Member's treating physician has recommended such participation after a determination by the physician that such participation may potentially provide a benefit to the Member.

"Routine patient care costs" do not include the following:

1. Drugs or devices that have not been approved by the FDA and are associated with the clinical

trial;
2. Services other than health care services, such as travel or housing expenses, companion expenses, and other non-clinical expenses that a Member might incur as a result of the Member's participation in the clinical trial;
3. Any item or services provided solely for the purpose of data collection and analysis;
4. Health care services that are otherwise specifically excluded from coverage under the Member's plan; or
5. Health care services customarily provided by researchers free of charge to participants in the clinical trial.

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.

Rehabilitation Services

Outpatient

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.

Behavioral Health Services

WHA has contracted with Human Affairs International of California (HAI-CA), an affiliate of Magellan Behavioral Health to administer all mental health and alcohol and drug abuse benefits under the plan. If you need behavioral health treatment or have questions about your behavioral heath benefits, please call HAI-CA at (800) 424-1778.

- **Inpatient - Mental Health**
  Members are entitled to receive inpatient hospital services for the treatment of Mental Health Disorders, at a participating acute care facility, subject to Copayments listed on the Covered Services Summary. Services are covered with Prior Authorization by the HAI-CA Medical Director.

- **Outpatient - Mental Health**
  Members are entitled to receive evaluation and short-term care by a Participating Provider, subject to copayments listed on the Covered Services Summary. Outpatient services for evaluation and short-term care are covered.

Severe Mental Health Services

Coverage for Serious Mental Illnesses and Serious Emotional disturbance of Children (SED) that have been pre-authorized by Magellan, the diagnoses include: SED, Schizophrenia, Schizoaffective Disorder, Pervasive Developmental Disorder or Autism, Obsessive-compulsive Disorder, Panic Disorder, major Depressive Disorder, Bipolar Disorder, Anorexia Nervosa and Bulimia Nervosa.

- **Inpatient**
  Members are entitled to receive inpatient hospital services for the treatment of severe psychiatric disorders as listed above at a participating acute care facility when authorized in advance by Magellan, subject to Copayment listed on the Covered Services Summary. (Unlimited Days)
- **Outpatient**
  Members are entitled to receive evaluation and short-term care (Unlimited Visits).

Alcoholism and Drug Abuse Services

- **Inpatient – Chemical Dependency**
  Members are entitled to receive short-term inpatient detoxification at a WHA acute care facility, subject to Copayment listed on the Covered Services Summary, upon Prior Authorization by Magellan or the Medical Director's alcoholism and drug abuse designee. Such facility must provide medical management of the Member for detoxification. Inpatient services do not include alcohol and chemical dependency rehabilitation services.
- **Outpatient – Chemical Dependency**
  Members are entitled to receive outpatient services for evaluation and short-term care for the treatment of alcoholism and chemical dependency by a Participating Provider, subject to Copayment listed on the Covered Services Summary and prior authorization by Magellan. Rehabilitation services are also covered.

Other Health Services

Short-term intermittent **Home Health Care Services**, up to 100 visits per calendar year, 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 Care**
  Hospice services are covered when a WHA member has met the hospice care requirements and a contracting physician authorizes the services. Hospice services must be medically necessary for palliation or management of the terminal illness in order to be covered. If a Plan physician diagnoses you with a terminal illness and determines that your life expectancy is six months or less, you may choose home-based hospice care instead of traditional services and supplies otherwise provided for your illness.

  If you elect hospice care, you are not entitled to any other services for the terminal illness under this evidence of coverage. You may change your decision to receive hospice care at any time. The member is required to elect hospice care and the attending physician is required to establish a plan

of care before services are provided. The signed election statement and contracting physician certification must accompany all hospice claims submitted for payment.

Under hospice care, we cover the following services and supplies when approved by a Plan physician and our hospice care team and provided by a licensed hospice agency approved by the Plan or the medical group:

1. Plan physician
2. Skilled nursing services
3. Physical, occupational, or respiratory therapy, or therapy for speech-language pathology
4. Medical social services
5. Home health aide and homemaker services
6. Palliative drugs prescribed for pain control and symptom management of the terminal illness in accord with our drug formulary and Plan guidelines. You must obtain these drugs from a contracting Plan pharmacy
7. Durable medical equipment in accord with Plan guidelines
8. Short-term inpatient care, including respite care, care for pain control, and acute and chronic symptom management
9. Counseling and bereavement services

- Short-term **skilled nursing facility** care is covered to a maximum of 100 days in each calendar year if medically necessary.

- **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.

  1. 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.
  2. 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.
  3. Where two or more alternative covered devices are appropriate to treat the Member's condition, the most cost effective device will be covered.
  4. 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.
  5. 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.

- **Mastectomy and Reconstructive Breast Surgery** to restore and achieve symmetry is covered in full. Coverage for a mastectomy shall include coverage for all complications from a mastectomy including Medically Necessary physical therapy to treat the complications of mastectomy, including lymphedema; prosthetic devices; or reconstruction of the breast on which, the mastectomy is Performed including areolar reconstruction and the insertion of a breast implant 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. The attending Physician and

surgeon consistent with sound clinical practice and in consultation with the patient will determine the length of the Hospital stay for mastectomies and lymph node dissection.

- **Diabetes supplies, equipment, and services** for the treatment and/or control of diabetes, including outpatient self-management training education and medical nutrition therapy. Outpatient self-management training education and medical nutrition therapy for the treatment and/or control of diabetes necessary to enable an enrollee to properly use the equipment, supplies, and medications upon the direction or prescription of those services by the enrollee's participating physician. The following equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin using diabetes, and gestational diabetes as medically necessary, even if the items are available without a prescription:
    1. Blood glucose monitors and blood glucose testing strips.
    2. Blood glucose monitors designed to assist the visually impaired.
    3. Insulin pumps and all related necessary supplies.
    4. Ketone urine testing strips.
    5. Lancets and lancet puncture devices.
    6. Pen delivery systems for the administration of insulin.
    7. Podiatric devices to prevent or treat diabetes-related complications.
    8. Insulin syringes.
    9. Visual aides, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

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

- **Testing and treatment of PKU** includes formula and special food products that are medially necessary for treatment of PKU and are prescribed.

- **Norplant** and other internally implanted time-release medications or contraceptives are covered at a Copayment of $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. Copayments will vary by type of infertility service provided. We cover the following services:
    1. Services and supplies for diagnosis and treatment of involuntary infertility
    2. Artificial insemination (except for donor semen or eggs, and services and supplies related to their procurement and storage), subject to a maximum of one treatment period of up to three (3) cycles per Lifetime.

- **Infertility Services Exclusions**
  All services and supplies (other than artificial insemination) related to conception by artificial means, such as, but not limited to:
    1. Invitro fertilization (IVF)
    2. Gamete Interfallopian Transfer (GIFT)
    3. Ovum transplants
    4. Donor semen or eggs, and services and supplies related to their procurement and storage
    5. Zygote intrafallopian transfer (ZIFT)
    6. Services and supplies to reverse voluntary, surgically induced infertility

- **Transplants** that are non-experimental or non-investigational are covered and must be ordered by

the Member's Participating Physician and approved by WHA's Medical Director in advance of surgery. The transplant must be performed at a center specifically approved and designated by WHA to perform these specific procedures. Coverage for a transplant where a Member is the recipient includes coverage for the medical and surgical expenses of a live donor, to the extent these services are not covered by another plan or program.

- **Emergency Medical Transport Services**
  Transport services are covered when ordered by a Participating Provider and determined to be Medically Necessary. Members have the right to access emergency health care services including the "911" emergency response system when and where the need arises. 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.

  The three tier Co Pay Plan is not a closed formulary, but three different co pays. Generic medications listed on the Preferred Drug List (PDL) are covered at the lowest co-payment. Brand name medications listed on the PDL are provided at the second co-payment level. Drugs which are not listed on the PDL are covered at the third (3rd) tier co-payment level, but generally do not require a prior authorization. There are a small number of drugs, regardless of tier level that may require Prior Authorization to ensure appropriate use based on criteria set by the WHA Pharmacy & Therapeutics (P&T) Committee. Members may request a copy of the PDL by calling (888) 563-2252 or view the document on the web page: www.westernhealth.com.

  Prescription drugs prescribed by a plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply. You pay a $10 co pay per prescription unit or refill for generic drugs or $20 co pay per prescription unit or refill for name brand drugs on the formulary, and a $35 co pay per prescription unit or refill for Non-Preferred (non-formulary) name brand medications per each 30-day supply or 120-unit supply, whichever is less. In no event will the co pay exceed the cost of the prescription drug. Brand Name medication dispensed if requested by physician or member, the Member will pay the Generic co pay plus the difference in cost between Generic and Brand name. If there is no Generic equivalent; Brand Name or Non-Formulary co pay applies.

  Covered prescription medications that are to be taken beyond 60 days are considered maintenance medications. Maintenance medications are used in the treatment of chronic conditions like arthritis, high blood pressure, heart conditions, and diabetes. Oral contraceptives are also available through the mail order program. Maintenance medications may be obtained through Medco, WHA's prescription benefit manager, mail order program. You can request the order form and brochure for this benefit by contacting Medco Member Services at (800) 903-8664 24 hours a day, 7 days a week.

  The initial prescription for maintenance medications is dispensed through a participating pharmacy (limited to a 30-day supply). Subsequent refills for a 90-day supply may be obtained through the Mail Order Program. You pay a $20 co pay for a 90-day supply of generic medication, a $40 co pay for a 90-day supply of brand name medication on the formulary, and a $70 co pay for a 90-day supply of brand name medication which is Non-Preferred (non-formulary) through the Mail Order Program. In this way, you receive a 90-day supply of medication for only two retail pharmacy co pays.

  Regardless of Medical Necessity or generic availability, you will be responsible for the Brand Name (Preferred or Non-Preferred) copayment when a Brand Name Medication is dispensed. If a Generic

Medication is available and you elect to receive a Brand Name Medication without medical indication from the prescribing physician, you will be responsible for the difference in cost between Generic and Brand Name in addition to the *Generic Copayment.* Copayments do not contribute to maximum out-of-pocket medical expenses. At retail pharmacies, if the actual cost of the prescription is less than the applicable co pay, the Member will only be responsible to pay the actual cost of the medication.

- **Covered prescription medications include:**
    1. Medications, which are Medically Necessary, which require a Prescription by state or federal law, and written by a Participating Physician and dispensed by a Participating Pharmacy.
    2. All FDA approved oral contraceptives and diaphragms.
    3. Prenatal Prescription vitamins or vitamins in conjunction with fluoride.
    4. Compounded Prescriptions, which contain at least one Prescription ingredient.
    5. Insulin and insulin syringes with needles and glucose test strips and tablets.
    6. Covered Prescription Medications dispensed by a non-Participating Pharmacy outside of Western Health Advantage's Service Area for urgent or Emergency Care only. You may submit your receipt to Western Health Advantage for reimbursement.
    7. Oral medications for the treatment of Infertility and Erectile Dysfunction require co pay equal to 50% of the contracted prescription cost.

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 and claim form to WHA's Member Services department, for reimbursement within 60 days of purchase. Your Copayment amount will be deducted from your reimbursement.

- **Prescription Exclusions and Limitations**

1. **Generic Medications are required.** The pharmacist will automatically substitute equivalent Generic Medication (when available) for the prescribed Brand Name Medication (Preferred or Non- Preferred) unless your physician writes, "do not substitute," or "prescribe as written," or it is included in the list of narrow therapeutic drugs for which there is more information below. A brand name drug will be provided if there is not generic equivalent available. There are certain drugs that currently have potential equivalency issues that are called "Narrow Therapeutic Index" (NTI) drugs. In such cases although a generic drug may be available, you will be provided the brand drug as written by your physician. A list of applicable NTI drugs can be found on our website or you may call customer service to obtain a list of the drugs. Unless there is no Generic Medication available, (like the Narrow Therapeutic Index drugs) the copayment for these drugs is the brand name copayment. If you request Brand Name Medications or your physician prescribes a Brand Name Medication, regardless of Medical Necessity or Generic availability, you will be responsible for the Brand Name Copayment when the Brand Name Medication is dispensed. If you elect to receive a Brand Name Medication without indication of medical necessity from your prescribing physician, you will be responsible for the difference between the cost of the Brand Name Medication and the Generic equivalent, in addition to the Generic Copayment.
2. Some Prescription Medications may require Prior Authorization by Western Health Advantage. For clarification, please contact Western Health Advantage at (888) 2-ASK-WHA. Prior authorization requests for routine/non-urgent requests are processed within 24 hours of receipt when all applicable information is included with the request. For urgent requests, coverage determinations are made within 1 – 4 hours of receipt of the request. An initial prior authorization form may be faxed to the reviewer and requests may also be made by telephone with all applicable information taken by the pharmacist. For a drug requiring Prior Authorization after business hours in an urgent/emergent situation, including weekends and holidays, the Plan has

arranged for the dispensing of an emergency short supply.

3. Covered Prescription Medications other than Maintenance Medications (see below) are normally limited to a 30-day supply. Prescriptions for controlled substances and other drugs not intended for continuous use may be limited to a smaller quantity per Copayment.
4. Covered Prescription Medications that are to be taken beyond 60 days are considered Maintenance Medications. Maintenance Medications may be obtained through Western Health Advantage'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 through the Mail Order Program.
5. Over-the-counter medications or medications that do not require a Prescription are excluded (except for insulin and insulin syringes with needles for diabetics).
6. Medications that are not Medically Necessary are excluded.
7. Treatment of impotence and/or sexual dysfunction must be medically necessary and documentation of a confirmed diagnosis of erectile dysfunction must be submitted to the Plan for review. Drugs and medications are limited to eight (8) pills per month for a 30 day period and are subject to a 50% co pay.
8. Medications that are experimental or investigational or are not FDA-approved or are not used for Approved Drug Usage (i.e., for the condition or indication for which they are prescribed) are excluded, except life-threatening or seriously debilitating conditions and cancer clinical trials as described in the Combined Evidence of Coverage, section titled, "Appeal for Investigational/Experimental Treatment".
9. Prescriptions written by dentists are excluded.
10. Drugs required for foreign travel are excluded, unless they are prior authorized for medical necessity.
11. Cosmetic products, health or beauty aids, dietary or nutritional aids, and all products to retard or reverse the aging of the skin, whether Prescription or non-Prescription, are excluded.
12. Drugs used for weight loss, including appetite suppressants, dietary or nutritional aids are excluded, unless they are prior authorized for medical necessity.
13. Contraceptive devices, including IUD's, and implantable contraceptives such as Norplant, are not covered under the pharmacy benefit; they are covered under the medical benefit as described in this Combined Evidence of Coverage, in the Principle Benefits and Covered Services section.
14. Medication for injection or implantation except insulin and other medications as determined by Western Health Advantage are covered under the medical benefit.
15. Pharmacies dispensing covered Prescription Medications to Members pursuant to the Agreement and this EOC do so as independent contractors. Western Health Advantage shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with any injuries suffered by Members.
16. Western Health Advantage shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with the manufacturing, compounding, dispensing, or use of any covered Prescription Medication.

- **Submitting Prescription Claims for Reimbursement**

  If you have to pay for a covered Prescription Medication as described in this Evidence of Coverage, submit your original receipt along with a copy of your Member identification card, address, a daytime telephone number, and the reason for the reimbursement request directly to Western Health Advantage within 60 days of purchase. No claim will be considered if submitted beyond 12 months from the date of purchase. Please direct all reimbursement requests to Western Health Advantage, 1331 Garden Highway, Suite 100, Sacramento, CA 95833, Attn: Member Service Department.

Principal Exclusions and Limitations

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

Exclusions

1. Any services or supplies obtained before the Member's effective date of coverage.
2. Service and supplies, which are not Medically Necessary.
3. Non-emergent 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.
4. Experimental medical or surgical procedures, services or supplies. Please refer to the Definitions section for "Experimental" criteria.
5. 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.
6. Cosmetic services and supplies are excluded, except for reconstructive surgery necessary to repair a functional disorder as a result of disease, injury, or congenital anomaly or Prosthetic Devices incident to a mastectomy as described in Principal Benefits and Covered Services. 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.
7. Rehabilitation Therapy Services, physical, speech, and occupational therapy provided in connection with the treatment of the following conditions:
8. Psychosocial speech delay, includes delayed language development;
9. Mental Retardation, Down Syndrome, Autism or Dyslexia;
10. Other syndromes attributing to perceptual and conceptual dysfunction, attention deficit disorder and associated behavioral problems;
11. Developmental articulation and language disorders and pervasive developmental disorder.
12. However, some of the above conditions shall be covered as shown in the "Covered Services" section, provided that their level of severity meets the criteria described in the definitions of Serious Emotional Disturbances of a Child" and/or "Severe Mental Illness."
13. 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.
14. Non-emergent medical transport inside or outside the Service Area, except with Prior Authorization.
15. 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.
16. Hearing aid batteries.
17. Services or supplies in connection with the storage of body parts, fluids or tissues, except for autologous blood.
18. 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 that is Medically Necessary to correct temporomandibular joint disease (TMJ) or other medical conditions, when Medically Necessary and Prior Authorized. Other dental services excluded include:
    - Items or services in connection with the care, treatment, fillings, removal, replacement, or

artificial restoration of the teeth or structures directly supporting the teeth.
    - 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.
19. Any services or supplies provided by a person who lives in the Member's home, or by an immediate relative of the Member.
20. Personal comfort or convenience items (e.g., television, radio), home or automobile modifications, or improvements (e.g., chair lifts, purifiers).
21. Vitamins (except prenatal prescription vitamins or vitamins in conjunction with fluoride).
22. Routine foot care (e.g., treatment of or to the feet for corns, or calluses), except when Medically Necessary. This exclusion includes Orthotic Devices for routine foot care. This exclusion does not include special footwear incident to foot disfigurement.
23. Chiropractic services, acupuncture, acupressure, biofeedback, sex therapy, dance therapy and recreational therapy.
24. All immunizations required by an employer as a condition of employment.
25. Services and supplies to reverse voluntary, surgically induced infertility. Embryo transfers and any services and supplies related to donor sperm or sperm preservation for artificial insemination, are excluded, including all services involved in surrogacy. All services and supplies (other than artificial insemination) related to conception by artificial means, such as, but not limited to:
    - Invitro fertilization (IVF)
    - Gamete Interfallopian Transfer (GIFT)
    - Ovum transplants
    - Donor semen or eggs, and services and supplies related to their procurement and storage
    - Zygote intrafallopian transfer (ZIFT)
    - Services and supplies in connection with the reversal of voluntary sterilization are excluded.
26. Sex Change (Transsexual) surgery is not a covered procedure.
27. Pregnancy under a surrogate arrangement. A surrogate pregnancy is one in which a woman has agreed to become pregnant with the intention of surrendering custody of the child to another person. In the event pregnancy services are rendered to a woman in a surrogate arrangement, the Plan has a right to impose a lien against any amount received by the surrogate/member for reasonable costs incurred by WHA.
28. Home birth delivery.
29. 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.
30. Non-prescription weight loss aids and programs and non-participating provider programs.
31. Smoking cessation products and programs.
32. 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.
33. Food supplements or infant formulas, except in the treatment of PKU.
34. Over-the-counter supplies or equipment that may be obtained without a prescription except for the treatment of diabetes.
35. Services and supplies that are in connection with the donation of organs where the recipient is not a member of WHA. Medically necessary services for the treatment of organ transplants where the Member is the organ recipient are covered, (see Transplants).
36. Court ordered health care services and supplies when not Medically Necessary.
37. Travel expenses including room and board even if the purpose is to obtain a Covered Service.
38. Expenses incurred for the purpose of obtaining copies of the medical records if requested by the Member for personal use.

39. 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 with a prior authorization is a covered benefit.
40. Testing for the sole purpose of determining paternity.
41. WHA does not cover diagnostic procedures or testing for genetic disorders, except for prenatal diagnosis of fetal genetic disorders in cases of high risk pregnancy.
42. 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.
43. Diagnosis and treatment for personal growth and/or development, personality reorganization or in conjunction with professional certification.
44. Marriage counseling, except for the treatment of a Mental Health Disorder/Condition.
45. Diagnosis and treatment of developmental disorders, including, but not limited to, developmental reading disorder, developmental arithmetic disorder or developmental articulation disorder, except that diagnosis and treatment of pervasive development disorders and autism are covered.
46. Ancillary services such as vocational rehabilitation, behavioral training, sleep therapy, employment counseling, training or education therapy for learning disabilities or other education services;
47. Psychological examination, testing or treatment for purposes of satisfying an employer's, prospective employer's or other party's requirements for obtaining employment, licensing or insurance, or for the purposes of judicial or administrative proceedings (including but not limited to parole or probation proceedings).
48. Psychological testing, except when conducted for the purpose of diagnosis of a Mental Health Disorder/Condition or a condition related to drug or alcohol dependence.
49. Mental health treatment of obesity or weight reduction (except in connection with anorexia nervosa or bulimia), including supplies.
50. Stress management therapy.
51. Aversion therapy.
52. Mental health treatment of pain, except for Medically Necessary treatment of pain with psychological or psychosomatic origins.

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 or injury must be in accordance with professionally recognized standards of practice.

1. 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 Provider panel and has been authorized in advance.
2. Physical, speech, and occupational therapy and cardiac and pulmonary rehabilitation are limited to short-term rehabilitation services.
3. 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 related requirement.
4. 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

or HAI-CA expense; or the Member is required to reimburse WHA or HAI-CA, respectively, for any expense incurred by WHA or HAI-CA. Members not legally required to be covered by Workers' Compensation benefits are eligible for 24-hour coverage under WHA.

5. WHA will not be held liable for the lack of available services in the event of a major disaster, epidemic, war, and 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.
6. For Covered Services, WHA reserves the right to coordinate your care in a cost effective and efficient manner.
7. Private hospital rooms and/or private duty nursing in connection with treatment of Mental Health Disorders/Conditions or conditions related to drug or alcohol dependence, unless determined to be Medically Necessary and authorized by HAI-CA.

Eligibility, Enrollment, and Termination

The following information applies to the University of California plan and supersedes any corresponding information that may be contained elsewhere in the document to which this insert is attached. The University establishes its own medical plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations ("Regulations") and any corresponding Administrative Supplements. Portions of these Regulations are summarized below.

Eligibility

The following individuals are eligible to enroll in this Plan. If the Plan is a Health Maintenance Organization (HMO), Point of Service (POS) or Exclusive Provider Organization (EPO) Plan, they are only eligible to enroll in the plan if they meet the Plan's geographic service area criteria. Anyone enrolled in a non-University Medicare Advantage Managed Care contract is not eligible for this plan.

To be eligible to enroll with WHA:

- All subscribers and dependents must live or work within a WHA licensed zip code, meaning that either their primary workplace or primary residence is within a WHA licensed zip code. See zip code listing on page 70. Subscribers must also fulfill their employers' eligibility requirements.
- A “primary residence” is defined as one in which the Subscriber and any covered Dependents permanently and physically reside in the residence, no less than eight (8) continuous months out of the calendar year.

Subscriber

Employee

You are eligible if you are appointed to work at least 50% time for twelve months or more or are appointed at 100% time for three months or more or have accumulated 1,000***** hours while on pay status in a twelve-month period. To remain eligible, you must maintain an average regular paid time****** of at least 17.5 hours per week and continue in an eligible appointment. 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)."

* Lecturers - see your benefits office for eligibility.

****** For any month, your average regular paid time is the average number of regular paid hours per week (excluding overtime, stipend or bonus time) worked by you in the preceding twelve (12) month period.

(a) A month with zero regular paid hours, which occurred during your furlough or approved leave without pay will not be included in the calculation of the average. If such absence exceeds eleven (11) months, the averaging will be restarted.

(b) A month with zero regular paid hours, which occurred during a period when you were not on furlough or approved leave without pay, will be included in the calculation of the average. After two consecutive such months, the averaging will be restarted.

For a partial month of zero regular paid hours due to furlough, leave without pay or initial employment the following will apply.

(a) If you worked at least 43.75% of the regular paid hours available in the month, the month will be included in the calculation of the average.

(b) If you did not work at least 43.75% of the regular paid hours available in the month, the month will not be included in the calculation of the

Retiree (including Survivor)

- **Retiree:** A former University Employee receiving monthly benefits from a University-sponsored defined benefit plan.
- **Survivor:** A deceased Employee's or Retiree's Family Member receiving monthly benefits from a University-sponsored defined benefit plan.

You may continue University medical plan coverage as a Retiree when you start collecting retirement or disability benefits from a University-sponsored defined benefit plan or as a Survivor when you start collecting survivor benefits from a University-sponsored defined benefit plan. You must also meet the following requirements:

(a) you meet the University's service credit requirements for Retiree medical eligibility;
(b) the effective date of your Retiree status is within 120 calendar days of the date employment ends (or the date of the Employee/Retiree's death for a Survivor); and
(c) you elect to continue medical coverage at the time of retirement.

If you are eligible for Medicare, see "Effect of Medicare on Retiree Enrollment" below.

Eligible Dependents (Family Members)

When you enroll any Family Member, your signature on the enrollment form or the confirmation number on your electronic enrollment attests that your Family Member meets the eligibility requirements outlined below. The University and/or the Plan reserves the right to periodically request documentation to verify eligibility of Family Members including any who are required to be your tax dependent(s). Documentation could include a marriage certificate, birth certificate(s), adoption records, Federal Income Tax Return, or other official documentation.

- **Spouse:** Your legal spouse.
- **Child:** All eligible children must be under the limiting age (18 for legal wards, 23 for all others), unmarried, and may not be emancipated minors. The following categories are eligible:
  a. your natural or legally adopted children;
  b. your stepchildren (natural or legally adopted children of your spouse) if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;
  c. grandchildren of you or your spouse if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;
  d. children for whom you are the legal guardian if living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental handicap may continue to be covered past age 23 provided:

- the incapacity began before age 23, the child was enrolled in a group medical plan before age 23 and coverage is continuous;
- the child is claimed as your dependent for income tax purposes or is eligible for Social Security Income or Supplemental Security Income as a disabled person or working in supported employment which may offset the Social Security or Supplemental Security Income; and

- the child lives with you if he or she is not your or your spouse's natural or adopted child.

Application must be made to the Plan at least 31 days before the child's 23rd birthday and is subject to approval by the Plan. The Plan may periodically request proof of continued disability. 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 incapacitated child, you may also apply for coverage for that child. The child must have had continuous group medical coverage since age 23, and you must apply for University coverage during your Period of Initial Eligibility.

Other Eligible Dependents (Family Members)

You may enroll a same-sex domestic partner (and the same-sex domestic partner's children/grandchildren/stepchildren) as set forth in the University of California Group Insurance Regulations.

Effective January 1, 2005, the University will recognize an opposite-sex domestic partner as a family member that is eligible for coverage in UC-sponsored benefits if the employee/retiree or domestic partner is age 62 or older and eligible to receive Social Security benefits and both the employee/retiree and domestic partner are at least 18 years of age.

An adult dependent relative is no longer eligible for coverage effective January 1, 2004. Only an adult dependent relative who was enrolled as an eligible dependent as of December 31, 2003 may continue coverage in UC-sponsored plans.

For information on who qualifies and how to enroll, contact your local Benefits Office or the University of California's Customer Service Center.

No Dual Coverage

Eligible individuals may be covered under only one of the following categories: as an Employee, a Retiree, a Survivor or a Family Member, but not under any combination of these. If an Employee and the Employee's spouse or domestic partner are both eligible Subscribers, each may enroll separately or one may cover the other as a Family Member. If they enroll separately, neither may enroll the other as a Family Member. Eligible children may be enrolled under either parent's or eligible domestic partner's coverage but not under both. Additionally, a child who is also eligible as an Employee may not have dual coverage through two University-sponsored medical plans.

Enrollment

For information about enrolling yourself or an eligible Family Member, see the person at your location who handles benefits. If you are a Retiree, contact the University's Customer Service Center. Enrollment transactions may be completed by paper form or electronically, according to current University practice. To complete the enrollment transaction, paper forms must be received by the local Accounting or Benefits office or by the University's Customer Service Center by the last business day within the applicable enrollment period; electronic transactions must be completed by midnight of the last day of the enrollment period.

During a Period of Initial Eligibility (PIE)

A PIE ends 31 days after it begins.

If you are an Employee, you may enroll yourself and any eligible Family Members during your PIE. Your PIE starts the day you become an eligible Employee.

You may enroll any newly eligible Family Member during his or her PIE. The Family Member's PIE starts the day your Family Member becomes eligible, as described below. During this PIE you may also enroll yourself and/or any other eligible Family Member if not enrolled during your own or their own PIE. You must enroll yourself in order to enroll any eligible Family Member. Family members are only eligible for the same plan you are enrolled in:

1. For a spouse, on the date of marriage.
2. For a natural child, on the child's date of birth.
3. For an adopted child, the earlier of:
   - the date you or your Spouse has the legal right to control the child's health care, or
   - the date the child is placed in your physical custody.

   If the child is not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date the adoption becomes final.
4. Where there is more than one eligibility requirement, the date all requirements are satisfied.

If you decline enrollment for yourself or your eligible Family Members because of other group medical plan coverage and you lose that coverage involuntarily, you may be able to enroll yourself and those eligible Family Members during a PIE that starts on the day the other coverage is no longer in effect.

If you are in an HMO, POS or EPO Plan and you move or are transferred out of that 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 yourself and your eligible Family Members in another University medical plan. Your PIE starts with the effective date of the move or the date you leave the Plan's service area.

At Other Times for Employees and Retirees

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

- If you are an Employee and opt out of medical coverage or fail to enroll yourself during a PIE or open enrollment period, you may enroll yourself at any other time upon completion of a 90 consecutive calendar day waiting period.
- If you are an Employee or Retiree and fail to enroll your eligible Family Members during a PIE or open enrollment period, you may enroll your eligible Family Members 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.
- If you have one or more children enrolled in the Plan, you may add a newly eligible Child at any time. See "Effective Date".
- If you are a Retiree, you may continue coverage for yourself and your enrolled Family Members in the same plan you were enrolled in immediately before retiring. You must elect to continue enrollment for yourself and enrolled Family Members before the effective date of retirement (or the date disability or survivor benefits begin).
- If you are a Survivor, you may not enroll your legal spouse or domestic partner.

Effective Date

The following effective dates apply provided the appropriate enrollment transaction (paper form or electronic) has been completed within the applicable enrollment period.

- If you enroll during a PIE, coverage for you and your Family Members is effective the date the PIE starts.
- If you are a Retiree continuing enrollment in conjunction with retirement, coverage for you and your Family Members is effective on the first of the month following the first full calendar month of retirement income.
- The effective date of coverage for enrollment during an open enrollment period is the date announced by the University.
- For enrollees who complete a 90-day waiting period, coverage is effective on the 91st consecutive calendar day after the date the enrollment transaction is completed.
- An Employee or Retiree already enrolled in adult plus child(ren) or family coverage may add additional children, if eligible, at any time after their PIE. Retroactive coverage is limited to the later of:
    1. the date the Child becomes eligible, or
    2. a maximum of 60 days prior to the date your Child's enrollment transaction is completed.

Change in Coverage

In order to change from single to adult plus child(ren) coverage, or two adult coverage, or family coverage, or to add another Child to existing family coverage, contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

Effect of Medicare on Retiree Enrollment

If you are a Retiree and you and/or an enrolled Family Member is or becomes eligible for premium free Medicare Part A (Hospital Insurance) as primary coverage, then that individual must also enroll in and

remain in Medicare Part B (Medical Insurance). Once Medicare coverage is established, coverage in both Part A and Part B must be continuous. This includes anyone who is entitled to Medicare benefits through their own or their spouse's non-University employment. Individuals enrolled in both Part A and Part B are then eligible for the Medicare premium applicable to this plan. Beginning January 1, 2004, Retirees or their Family Member(s) who become eligible for premium free Medicare Part A and do not enroll in Part B, will permanently lose their UC-sponsored medical coverage.

Retirees and their Family Members who were eligible for premium free Medicare Part A, but declined to enroll in Part B of Medicare before January 1, 2004, were assessed a monthly offset fee by the University to cover increased costs. The offset fee may increase annually, but will stop when the Retiree or Family Member becomes covered under Part B. Retirees or Family Members who are not eligible for premium free Part A will not be assessed an offset fee nor lose their UC-sponsored medical coverage. Documentation attesting to their ineligibility for Medicare Part A will be required. (Retirees/Family Members who are not entitled to Social Security and premium free Medicare Part A will not be required to enroll in Part B.)

You should contact Social Security three months before your or your Family Member's 65th birthday to inquire about your eligibility and how you enroll in the Hospital (Part A) and Medical (Part B) portions of Medicare. If you qualify for disability income benefits from Social Security, contact a Social Security office for information about when you will be eligible for Medicare enrollment.

Upon Medicare eligibility, you or your Family Member must complete a University of California Medicare Declaration form as well as submit a copy of your Medicare card. This notifies the University that you are covered by Part A and Part B of Medicare. The University's Medicare Declaration forms are available through the University's Customer Service Center. Completed forms should be returned to University of

California, Human Resources and Benefits, Health & Welfare Administration – Retiree Insurance Program, Post Office Box 24570, Oakland, CA 94623-9911.

Any individual enrolled in a University-sponsored Medicare Advantage Managed Care Contract must assign his/her Medicare benefit to that plan or lose UC-sponsored medical coverage.

Medicare Secondary Payer Law (MSP)

The Medicare Secondary Payer (MSP) Law affects the order in which claims are paid by Medicare and an employer group health plan. UC Retirees hired into positions making them eligible for UC-sponsored medical coverage, including CORE and mid-level benefits, are subject to MSP. For Employees or their spouses who are age 65 or older and eligible for a group health plan due to employment, Medicare becomes the secondary payer and the employer plan becomes the primary payer.

Medicare Private Contracting Provision

Federal Legislation allows physicians or practitioners to opt out of Medicare. Medicare beneficiaries wishing to continue to obtain services **(that would otherwise be covered by Medicare)** from these physicians or practitioners will need to enter into written "private contracts" with these physicians or practitioners requiring the beneficiary to be responsible for all payments to such providers. Services provided under "private contracts" are not covered by Medicare, and the Medicare limiting charge will not apply.

If you are classified as a Retiree by the University (or otherwise have Medicare as a primary coverage) and enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement with one or more physicians or practitioners, under the law you have in effect "opted out" of Medicare for the services provided by these physicians or other practitioners. No benefits will be paid by this Plan for services rendered by these physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered.

However, if you do sign a private contract with a physician or practitioner, you may see other physicians or practitioners without those private contract restrictions as long as they have not opted out of Medicare.

Termination of Coverage

The termination of coverage provisions that are established by the University of California in accordance with its Regulations are described below. Additional Plan provisions apply and are described elsewhere in the document.

Disenrollment Due to Loss of Eligible Status

- If you are an Employee and lose eligibility, your coverage and that of any enrolled Family Member stops at the end of the last month in which premiums are taken from earnings based on an eligible appointment.
- If you are a Retiree or Survivor and your annuity terminates, your coverage and that of any enrolled Family Member stops at the end of the last month in which you are eligible for an annuity.
- If your Family Member loses eligibility, you must complete the appropriate transaction to delete him or her within 60 days of the date the Family Member is no longer eligible. Coverage stops at the end of the month in which he or she no longer meets all the eligibility requirements. For information on disenrollment procedures, contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

Disenrollment Due to Fraud

Coverage for you or your Family Members 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. Such termination shall be effective upon the mailing of written notice to the Subscriber (and to the University if notice is given by the Plan). A Family Member who commits fraud or deception will be permanently disenrolled while any other Family Member and the Subscriber will be disenrolled for 12 months. If a Subscriber commits fraud or deception, the Subscriber and any Family Members will be disenrolled for 12 months.

Leave of Absence, Layoff or Retirement

Contact your local Benefits Office for information about continuing your coverage in the event of an authorized leave of absence, layoff or retirement.

Optional Continuation of Coverage

If your coverage or that of a Family Member ends, you and/or your Family Member may be entitled to elect continued coverage under the terms of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended and if that continued coverage ends, specified individuals may be eligible for further continuation under California law. The terms of these continuation provisions are contained in the University of California notice "Continuation of Group Insurance Coverage", available from the University's "At Your Service" website (http://atyourservice.ucop.edu). The notice is also available from the person in your department who handles benefits and from the University's Customer Service Center. You may also direct questions about these provisions to your local Benefits Office or to the University's Customer Service Center if you are a Retiree.

Introduction to COBRA and Cal-COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (a federal law usually known simply as "COBRA"), if you lose coverage under the Western Health Advantage medical plan due to certain "Qualifying Events" (described below), you or your spouse or dependent children may be entitled to elect continuation coverage at your own expense. In certain instances (e.g. your death), your spouse or dependent children may also have a right to elect coverage for themselves. (You, your eligible dependent spouse and your eligible dependent children are sometimes called "Qualified Beneficiaries" in this summary.)

Not everyone is entitled to elect COBRA continuation coverage. In general, COBRA benefits are only available to Qualified Beneficiaries that are covered by a group health plan maintained by an employer with twenty (20) or more employees. However, California has enacted a separate law known as the California Continuation Benefits Replacement Act, or "Cal-COBRA," that may give you an additional right to elect continuation coverage. Under Cal-COBRA you may be entitled to elect continuation coverage even if you are covered by a small employer (2-19 employees) group health plan and are ineligible to elect federal COBRA coverage.

Effective September 1, 2003, Cal-COBRA will provide an additional benefit to Qualified Beneficiaries eligible for federal COBRA coverage: at your option you may extend your continuation coverage up to a total of thirty-six (36) months as a matter of state law after your right to receive COBRA continuation coverage has expired.

Under both COBRA and Cal-COBRA, all benefits you receive under continuation coverage are the same as the benefits available to active eligible employees and their eligible dependents. If coverage is modified for active eligible employees and their eligible dependents, it will be modified in the same

manner for you and all other Qualified Beneficiaries. In that case, an appropriate adjustment in the premium for continuation coverage may be made. If your
employer's group health plan with Western Health Advantage terminates before your continuation coverage expires, you may maintain your coverage for the balance of your continuation period as if the group health plan had not terminated, so long as, within thirty (30) days of your receipt of notice of the termination, you comply with any requirements that may be imposed regarding enrollment and payment of premiums resulting from the termination. (See "Normal Period of Cal-COBRA Continuation Coverage" below.")

You do not need to submit evidence of insurability to obtain COBRA or Cal-COBRA continuation coverage. Additionally, if you meet all the eligibility requirements and you submit your election form and premium on time, you cannot be denied COBRA or Cal-COBRA continuation coverage.

If you are self-employed and are not covered by a group health plan maintained by an employer with at least 2 employees, you are not eligible for either COBRA or Cal-COBRA.

Certain other people are not eligible to elect continuation coverage under COBRA or Cal-COBRA. See the Sections below entitled "COBRA Benefits" and "Cal-COBRA Benefits" for more information about coverage and exclusions.

COBRA Benefits

Your Right to Elect Continuation Coverage

In general, you are entitled to elect COBRA continuation coverage if you are a covered employee under your employer's group health plan, or if you are the spouse or dependent child of a covered employee. COBRA benefits also extend to any child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage. However, small-employer group health plans (generally, less than twenty (20) employees) are exempt from COBRA, as are government health plans and church plans.

If your employer's health plan is subject to COBRA, you have the right to elect continuation coverage for yourself and your eligible dependent spouse and children if your ordinary plan coverage would have ended for either of the following events (events triggering a right to elect continuation coverage are called "Qualifying Events"):

1. Your employment ends for a reason other than gross misconduct; or
2. Your work hours are reduced (including approved leave without pay or layoff).

Right of your Dependent Spouse & Children to Elect COBRA Continuation Coverage

Your eligible dependent spouse and each eligible dependent child has the separate right to elect continuation coverage upon the occurrence of any of the following Qualifying Events, if written notification is sent to Western Health Advantage – or to the employer if the employer administers the plan under contract with Western Health Advantage – not later than sixty (60) days after the date of the Qualifying Event.

In the case of your Eligible Dependent Spouse

Your spouse may elect continuation coverage, which may include enrolled dependent children, if your spouse's coverage would have ended because of any of:

1. Your death; or
2. The termination of your employment for a reason other than your gross misconduct, or the reduction of your work hours (including approved leave without pay or layoff); or
3. Your divorce or legal separation from your spouse, or the annulment of your marriage;

4. You become entitled to Medicare benefits; or
5. A dependent enrolled in your group benefit plan loses dependent status.

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:

1. Your death; or
2. The termination of your employment for a reason other than gross misconduct, or the reduction of your work hours (including approved leave without pay or layoff); or
3. Your divorce or legal separation from your spouse, or the annulment of your marriage; or
4. You become entitled to Medicare benefits; or
5. Your eligible dependent child ceases to be an eligible dependent under the rules of the plan.

Cal-COBRA Benefits

Under Cal-COBRA, you may be able to take advantage of additional benefits not available to you under federal COBRA. If you are covered by a small employer group health plan (less than twenty (20) employees) and thus are ineligible for COBRA continuation coverage, you and/or your eligible dependent spouse and eligible dependent children may elect continuation coverage under Cal-COBRA for up to thirty-six (36) months following the occurrence of a Qualifying Event, by notifying Western Health Advantage in writing, or notifying your employer in writing if your employer administers the plan under contract with Western Health Advantage, not later than sixty (60) days after the Qualifying Event.

Additionally, if you exhaust your federal COBRA benefits after September 1, 2003, you and/or your eligible dependent spouse and eligible dependent children may elect and maintain additional continuation coverage under Cal-COBRA, up to a total of thirty-six (36) months of combined COBRA and Cal-COBRA continuation coverage, following the occurrence of a Qualifying Event. To elect additional Cal-COBRA coverage after exhaustion of your federal COBRA benefits, you must notify Western Health Advantage in writing not later than thirty (30) days *prior* to the date your federal COBRA coverage period ends.

Multiple Qualifying Events

The total period of continuation coverage under Cal-COBRA cannot exceed 36 months no matter how many qualifying events may occur. For example, if you elect continuation coverage for yourself and your spouse because your employment is terminated (the first Qualifying Event), but you die during the continuation period (the second Qualifying Event), your spouse may elect to continue the coverage by sending the required notice within 60 days after the second qualifying event (i.e., your death). However, your spouse may not receive, in total, more than 36 months of continuation coverage, beginning from the date your employment was originally terminated.

Exclusions from Cal-COBRA

Cal-COBRA will not apply, and your entitlement to continuation coverage will terminate if it is already in effect, if: (i) you become eligible for Medicare benefits (even if you do not choose to enroll in Medicare Part B); (ii) you become covered by another group health plan that does not exclude or limit any preexisting condition you may have; (iii) you become eligible for federal COBRA by virtue of certain provisions of the Internal Revenue Code or ERISA; (iv) you become eligible for coverage under a government health plan governed by the Public Health Service Act; or (v) you fail to notify WHA within applicable time limits of a qualifying event or coverage election, you fail to pay your premium on time, or you commit fraud or deception in the use of WHA's health plan services.

Electing COBRA and Cal-COBRA Continuation Coverage

You elect continuation coverage under COBRA and Cal-COBRA in the same way, although the rates for COBRA and Cal-COBRA may be different. Once you have made Western Health Advantage or your Employer aware of a

Qualifying Event, you will be given a form with which to elect continuation coverage. The form will advise you of the amount of premium required for the continuation coverage. (See below for premium limits.) Please follow the directions on the form to elect continuation coverage. Send the notice to the following address, unless directed otherwise on the form:

Western Health Advantage
Attn: COBRA Enrollment Department
1331 Garden Highway, Suite 100
Sacramento, CA 95833-9754
(916) 563-2252 or (888) 563-2252

The notice must be delivered by first class mail, overnight courier or some other reliable means of delivery. Personal delivery is also acceptable. Please remember that the form must be completed and returned to the address above, 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 you received notice informing you of the right to elect continuation coverage. *Failure to make the required notification within the 60-day time limit will disqualify you from participating in Cal-COBRA continuation coverage*.
Your first premium payment must be delivered to Western Health Advantage or to your employer if your employer administers the plan under contract with Western Health Advantage, not later than forty-five (45) days following the date you provided written notice of your coverage election. The premium must be delivered by first class mail, overnight courier or some other reliable means of delivery. Personal delivery is also acceptable. The amount remitted must be sufficient to pay all premium amounts due. *Please note that failure to pay the required premium within the 45-day time limit will disqualify you from participating in Cal-COBRA continuation coverage, even if you have previously made a timely election*.

Termination of COBRA/Cal-COBRA Continuation Coverage

Once continuation coverage is elected, the coverage period will run concurrently with any other continuation provisions (e.g., during leave without pay) *except* continuation under the Family and Medical Leave Act (FMLA).

Normal Period of COBRA Continuation Coverage

Continuation coverage begins on the date of the Qualifying Event and – unless terminated prematurely (see "Premature Termination" below) – continues for eighteen (18) months from the date of the Qualifying Event. However, if you or your eligible dependent spouse or children are disabled within the meaning of Title II or XVI of the Social Security Act, coverage will continue for twenty-nine (29) months.

Normal Period of Cal-COBRA Continuation Coverage

Continuation coverage begins on the date of the qualifying event and continues for thirty-six (36) months, unless earlier terminated (see "Premature Termination" below).

If you (or your eligible dependent spouse or children) are covered by federal COBRA and have elected Cal-COBRA continuation coverage not later than thirty (30) days prior to the expiration of the federal COBRA coverage period, Cal-COBRA continuation coverage will terminate thirty-six (36) months

following the date of the first qualifying event. However, an election to extend federal COBRA under the provisions of Cal-COBRA will not be effective until September 1, 2003.

If your employer's group health plan with Western Health Advantage terminates before your continuation coverage expires, you may nevertheless maintain your coverage for the balance of your continuation period as if the group health plan had not terminated, so long as, within thirty (30) days of your receipt of notice of the termination, you comply with any requirements that may be imposed regarding enrollment and payment of premiums resulting from the termination. Failure to comply with applicable enrollment and premium requirements will cause your continuation coverage to end.

Premature Termination of COBRA or Cal-COBRA

Your coverage (or the coverage of your eligible dependent spouse or children) under both COBRA and Cal-COBRA will terminate before the end of the normal continuation coverage periods upon the occurrence of any of the following events:

1. If you (or your eligible dependent spouse or children) fail to make a required premium payment. (Continuation coverage will automatically terminate as of the end of the period for which all required payments have been made.)
2. As of the date new coverage takes effect for you (or your eligible dependent spouse or children) under any other group health plan.
3. As of the date you (or your eligible dependent spouse or children) become entitled to Medicare benefits.
4. As of the date your Employer no longer provides group health coverage to any of its Employees.
5. As of the date you (or your eligible dependent spouse or children) move out of Western Health Advantage's service area, or commit fraud or deception in the use of its plan services.

Cost of Continuation Coverage under COBRA and Cal-COBRA

The cost of continuation coverage under both COBRA and Cal-COBRA will include the premium previously paid by the employee as well as any portion previously paid by the Employer. Under federal COBRA, the rate will be not more than 102% of the applicable group coverage rate. Under Cal-COBRA, the rate can be up to 110% of the applicable group coverage rate. Finally, you may be required to pay up to 150% of the applicable group coverage rate if you are receiving continuation coverage past the 18-month federal COBRA period due to disability).

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/medlearn/hipaa.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.

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.

Conversion Option

An employee or member whose coverage under the group contract has been terminated by the employer may be entitled to convert to a non-group conversion plan without evidence of insurability. A conversion contract shall not be required to be made available in the following circumstances:

1. The group contract terminated or an employer's participation terminated and the group contract is replaced by similar coverage under another group contract within 15 days of the date of termination of the group coverage or the subscriber's participation.
2. The employee or member failed to pay amounts due.
3. The employee or member was terminated by the health care service plan from the plan for good cause.
4. The employee or member knowingly furnished incorrect information or otherwise improperly obtained the benefits of the plan.
5. The employee or member is covered by or is eligible for benefits under Title XVIII of the United States Social Security Act.
6. The employee or member is covered by or is eligible for benefits under any group contract.
7. The employee or member is covered for similar benefits by an individual policy or contract.
8. The employee or member has not been continuously covered during the three-month period immediately preceding that person's termination of coverage.

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.

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.

- Fees are not received within the specified period. Termination is effective on the last day of the period for which appropriate fees were received.
- If a member fails to pay the required copayments to any Participating Provider for services rendered after being properly notified and billed and Member fails to comply with or is unwilling to make payment arrangements within 45 days, a cancellation notice will be mailed and shall be effective upon the mailing of written notice by the Plan to the Subscriber and Employer.
- If a Member frequently or repeatedly misses or cancels appointments with less than twenty-four (24) hours notice, and that the reason for the missed or cancelled appointments is not due to the nature of

the member's medical condition, both WHA and the Member's Primary Care Physician, will provide the member with written notification of the problem and give the member a reasonable opportunity to correct it. If the member fails to correct the problem after receiving a written warning letter from the PCP, WHA may cancel coverage of that Member. The Member will receive a final warning letter from WHA and then a written termination notice. Termination shall be effective upon the mailing of written notice by the Plan to the Subscriber and Employer.

- Incorrect or misleading information is provided as it pertains to you and/or your families' receipt of "healthcare services." Termination shall be effective upon the mailing of written notice by the Plan to the Subscriber and Employer.
- Seeking and/or obtaining medications under false pretenses to support a drug dependency or for the illegal sale of the medications.
- A member may be terminated if the member threatens the safety of Plan employees, providers, or an HAI-CA provider or employee, or members, or other patients, or the member's repeated behavior has substantially impaired the Plan's ability to furnish or arrange services for the member or other members, or substantially impaired a provider's ability to provide services to other patients.
- If a Subscriber no longer works or maintains a permanent primary residence within the Service Area, coverage will be terminated for the Subscriber and any enrolled Family Members effective midnight of the last day of the month in which such event occurred. A "primary residence" is defined as one in which the Subscriber and any covered Dependents permanently and physically reside in the residence, no less than 8 continuous months out of the calendar year. However, coverage may be continued for a Subscriber and any enrolled Family Members 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 four (4) months. Coverage may also be continued for any Family Member 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 Family Member qualifies as the Subscriber's dependent under Internal

  Revenue Service standards. In such cases, coverage for services received outside the Service Area shall be limited to Urgent Care or 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 Family Member makes a false statement, misrepresentation, or omission, in the application and enrollment forms, a response to a subordination request from WHA or HAI-CA, or any other correspondence or communication with WHA or HAI-CA, 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 immediately upon written notice.

Please note that coverage may be terminated by giving written notice that you wish to disenroll. You are responsible for notifying any Family Members that coverage has been canceled.

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 your enrolled Family Members are a registered bed patient in a hospital at the date of termination. You or your enrolled Family Members 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 your enrolled Family Member is 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 one 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 Family 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 Family 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.

Subscribers may cancel medical plan coverage or delete a Family Member from the Plan at any time by submitting the appropriate forms to their local Benefits Office or by completing the appropriate electronic transaction. However, a Retiree's Plan coverage must be continuous. **Once Medical Plan coverage as a Retiree 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 Department of Managed Healthcare.

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 document 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 document and/or the Group Hospital and Professional Service Agreement. What is written in this document 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 what your rights are.

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
(800) 888-8267

Retirees may also direct questions to the University's Customer Service Center at the above phone number.

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

Western Health Advantage
1331 Garden Hwy, Suite 100
Sacramento, CA 95833
(916) 563-2252

Group Contract Number

The Group Contract 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. Plan benefits are not accrued or vested benefit entitlements. The right to terminate or amend applies to all Employees, Retirees 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 premiums that University pays is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation.

Financial Arrangements

The benefits under the Plan are provided by Western Health Advantage, under a Group Service Agreement. The cost of the premiums is currently shared between you and the University of California.

Agent for Serving of Legal Process

Legal process may be served on Western Health Advantage at the address listed above.

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 and other specified sites, all Plan documents, including the Group Service Agreement, at a time and location mutually convenient to the participant and the Plan Administrator.
- Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

Claims under the Plan

To file a claim or to appeal a denied claim, refer to the **Member Satisfaction Procedure** section of this document.

Nondiscrimination Statement

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

Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Director of Diversity and Employee Programs, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Director of Academic Affirmative Action, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

Financial Considerations

Fees

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

Other Charges - Copayments

You are responsible for 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 $1,000 for an individual and $3,000 for a family of two or more.

The following Co-payments or expenses paid will not be applied to the MCL amounts:

- Prescription Drug Copayments, which includes oral and injectable medications

You are required to continue to pay these Co-payments after the MCL has been reached.

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 the event a Member is injured due to the act or omission of a third party (including, but not limited to,

motor vehicle accidents, falls and Workers' Compensation cases) and complications incident thereto, WHA will furnish Covered Services. However, in the event of any recovery is obtained 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:

1. Each Member will give prompt notification to WHA of the name and location of the third party, any involved insurance companies, carriers, and adjusters, if known, and the circumstances which caused the injuries; and
2. 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.
3. Immediately upon receiving any Recovery as specified herein, each Member will reimburse WHA for the value of the services and benefits, as set forth below. Any such Recovery by or on behalf of Member or Member's attorney or other representative will be held in trust for the benefit of WHA and will not be used or disbursed for any other purpose without WHA's express prior written consent. If Member receives a judgment, compromise, or settlement, which does not specifically include an award for medical costs, WHA will nevertheless have a lien against such Recovery.

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

Where used within this provision, "WHA" refers to Western Health Advantage, and/or Participating Hospitals or Physicians providing Covered Services. "Recovery" refers to any compensation received from a final judgment, compromise or settlement received in connection with a civil, criminal or administrative claim, complaint, lawsuit, arbitration, mediation, grievance or proceeding which arises from the act or omission of a third-party.

[The Following Sections are not applicable to workers' compensation liens or certain hospital liens.]

The lien of WHA on a Member's Recovery will not exceed the reasonable costs actually paid by WHA to perfect the lien plus, if the Covered Services were provided on a noncapitated basis, the amount paid for Covered Services or, if provided on a capitated basis, an amount equal to 80% of the usual and customary charge for the same services by medical providers that provide health services on a noncapitated basis in the geographic region where services were provided. If Member receives Covered Services on both a capitated and noncapitated basis, WHA's lien will not exceed the total of the above sums.

If Member engaged an attorney, WHA's lien will not exceed the lesser of the following: 1) the maximum amount determined pursuant to the preceding paragraph; or 2) one-third of the Recovery. If the Member did not engage an attorney, WHA's lien will not exceed the lesser of the following: 1) the maximum amount determined pursuant to the preceding paragraph; or 2) one-half of the Recovery.

A reduction of WHA's lien will be allowed if any final judgment includes a special finding by a judge, jury or arbitrator that the Member was partially at fault. The reduction will be the same comparative fault percentage by which the Member's Recovery was reduced. A pro rata reduction of WHA's lien will also be allowed commensurate with the Member's reasonable attorney's fees and costs.

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 military benefits. 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, 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.

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.

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 PCP. If you need help answering your questions, clarifying procedures, submitting a claim, or investigating complaints, call Member Services between 8 a.m. and 5 p.m. Monday through Friday, at (916) 563-2252 / (888) 563-2252. If you prefer, you can visit or write to:

Western Health Advantage
Member Services Department
Attn: 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
Attn: Appeals Department
1331 Garden Highway, Suite 100
Sacramento, CA 95833
(888) 563-2252

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 period, please contact Member Services on how to proceed.

WHA sends an acknowledgment letter to the Member within three (3) 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 and written notification of the disposition of the appeal will be sent to the member and will include an explanation of the contractual or clinical rationale for the decision Contact Member Services for more detailed information about the appeals and grievance procedure.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (916) 563-2252 and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (888) HMO-2219 and a TDD line (877) 688-9891 for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

The Plan's grievance process and the department's complaint review processes are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

Grievances related to Mental Health or Chemical Dependency Detoxification Benefits.
HAI-CA administers all levels of review under WHA's Grievance Process for complaints regarding mental health or chemical dependency/detoxification services. If you have an inquiry or concern regarding your mental health or chemical dependency/detoxification benefits, you should first call HAI-CA's Customer Service Department at (800) 424-1778. Every effort will be made to resolve your inquiry or concern informally through the Customer Service Department. If you are not satisfied with this resolution, you may submit a formal verbal or written grievance to HAI-CA's Grievance Unit at: 300 Continental Boulevard, Suite 240, El Segundo, CA, 90245, Attention: Comment Coordinator, or call (800) 424-1778. (Grievance forms and filing information are available through HAI-CA's Customer Service Department.)

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.

Independent Medical Review

WHA allows members the opportunity to seek an independent medical review whenever covered health care services have been denied, modified, or delayed by the plan, its contracting medical groups or contracted providers if the decision was based in whole or part on findings that the proposed services were not medically necessary. A decision regarding a Disputed Health Care Service relates to the practice of medicine and is not a Coverage Decision. If a decision to deny, modify, or delay health care services, is based in whole or in part on a finding that the services are not a covered benefit under the contract that applies to the member, the statement of decision must clearly specify the provision in the contract that excludes the coverage in question in the correspondence. All member grievances involving a Disputed Health Care Service, are eligible for review under the Independent Medical Review System if all requirements are met, which are:

1. the member's provider has recommended the health care services as medically necessary, or
2. member has received an urgent care or emergency service that a provider determined was medically necessary, or
3. in the absence of a) and b) above has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the member seeks independent review. The Disputed Health Care Service has been denied, modified, or delayed based on a decision that it is not medically necessary and the member has filed a grievance with the Plan and the decision is upheld or remains unresolved past 30 days.

If you would like to apply for Independent Medical Review, please call our Member Services Department between 8 a.m. and 5 p.m. Monday through Friday, at (916) 563-2252 / (888) 563-2252 to request the application form. Or, if you prefer, you can come directly to our office or request the form in writing at:

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

Members may request an independent medical review from the Department of Managed Health Care (DMHC). There is no application or processing fee required. When WHA receives notice from DMHC regarding the Member's request for an Independent Medical Review, WHA will submit the documents required by H&S §1374.30(n) within 3 days. The decision of the Independent Medical Review agency is binding on WHA.

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 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 verbal or written. The written request is to be submitted to:

Western Health Advantage
Attn: Appeals Department
1331 Garden Highway, Suite 100
Sacramento, CA 95833
(888) 563-2252

WHA Members have the right to request an independent medical review when coverage is denied as an Experimental or Investigational Procedure when 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:

1. 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
2. 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. Upon notice from the department that the health care service plan's enrollee has applied for an independent medical review, the plan or its contracting providers shall provide to the independent medical review organization designated by the department a copy of all of the following documents within three business days of the plan's receipt of the department's notice of a request by an enrollee for an independent review: A copy of all of the enrollee's medical records in the possession of the plan or its contracting providers relevant to each of the following:

- The enrollee's medical condition.
- The health care services being provided by the plan and its contracting providers for the condition.
- The disputed health care services requested by the enrollee for the condition.

If the member is not in a life threatening or seriously 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

Typically such disputes are handled and resolved through the WHA's Grievance, Appeal, and Independent Medical Review process described above. However, in the event that a dispute is not resolved in that process, WHA uses binding Arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as employer

groups, health care providers or their agents or employees, are also involved. In addition, disputes with WHA involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered) also must be submitted to binding arbitration.

As a condition to becoming a WHA Member, you agree to submit all disputes you may have with WHA, except those described below, to final and binding arbitration. Likewise, WHA agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both you and WHA are bound to use binding Arbitration as the final means of resolving disputes that may arise between the parties, and thereby the parties agree to forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by WHA's binding Arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter. WHA's binding Arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitration's under this process.

If the parties fail to reach an agreement during this time frame, then either party may apply to a Court of Competent Jurisdiction for appointment of the arbitrator(s) to hear and decide the matter. Arbitration can be initiated by submitting a demand for Arbitration to WHA at the address provided below.

The demand must have a clear statement of the facts, the relief sought and a dollar amount and be sent to:

Western Health Advantage
Attn: CFO
1331 Garden Highway, Suite 100
Sacramento, CA 95833

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.

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this Evidence of Coverage, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law. The award will be final and binding on all parties except to the extent that State or Federal law provide for judicial review of Arbitration proceedings.

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees. In cases of extreme hardship to a Member, WHA may assume all or a portion of a Member's share of the fees and expenses of the Arbitration. Upon written notice by the Member requesting a hardship application, WHA will forward the request to an independent professional dispute resolution organization for a determination. Such request for hardship should be submitted to the Litigation Administrator at the address provided above. Effective July 1, 2002, Members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are *not* required to submit disputes about certain "adverse benefit determinations" made by WHA to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by WHA to deny, reduce, terminate or not pay for all or a part of a benefit. However, you and WHA may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

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.

"Brand Name Medication" means a Prescription drug manufactured, marked, and sold under a given name.

"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.

"Child" see Eligibility, Enrollment and Termination section.

"Complaint" is any written or oral expression of dissatisfaction and shall include any complaint, dispute, request for reconsideration or appeal made by a member, the member's representative or Provider, about their experience with WHA, a Medical Group and /or any WHA providers.

"Copayment" means an additional fee charged to a Member, which is approved by the Department of Managed Health 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 Co payments paid over the contract year.

"Coverage Decision" means the approval or denial of health care service by a plan or by one of its contracting medical groups, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the Plan contract. It does not encompass a decision regarding a Disputed Health Care Service.

"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.

"Disputed Health Care Service" means any health care service eligible for coverage and payment under a health care service plan contract that has been denied, modified, or delayed by a decision of the plan, by one of its contracting medical groups or provider, in whole or in part due to a finding that the service is not medically necessary. A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage decision.

"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.

"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:

1. The Diagnostic and Therapeutic Technology Assessment Project of the American Medical Association;
2. The Center of Healthcare Technology;
3. The National Institute of Health;
4. The Federal Food and Drug Administration;
5. The specialty board and the academy it represents as recognized by the American Board of Medical Specialties (ABMS) or
6. 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.

"Generic Medication" A Prescription drug that is medically equivalent to a Brand Name Medication as determined by the United States Food and Drug Administration and meets the same standards as a Brand Name Medication in al facets: purity, safety, strength and effectiveness.

"Grievance" is any written or oral expression of dissatisfaction and shall include any complaint, dispute, request for reconsideration or appeal made by a member, the member's representative or Provider, about their experience with WHA, a Medical Group and/or any WHA providers. Grievance is a stage in the appeals process

"Group Agreement" the Group Medical & 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.

"Independent Medical Review" means a member has the opportunity to seek an Independent Medical Review whenever health care services have been denied, modified, or delayed by the plan or by one of it contracting medical groups or providers if the decision was based on a finding that the proposed services are not medically necessary.

"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.

"Maintenance Medication" Any covered Prescription Medications that are to be taken beyond 60 days. Examples include medications such as those for high blood pressure, diabetes, arthritis, some allergy medications and oral contraceptives.

"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 PCP 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.

"Member Satisfaction Procedure" is the process a member may communicate their concerns regarding their care either verbally or in writing, with WHA. Generally there are three categories and they are defined below:

- An “**Appeal**” is a formal request 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.
- A “**Complaint**” is any written or oral expression of dissatisfaction and shall include any complaint, dispute, request for reconsideration or appeal made by a member, the member’s representative or Provider, about their experience with WHA, a Medical Group and /or any WHA providers.
- A “**Grievance**” is any written or oral expression of dissatisfaction and shall include any complaint, dispute, request for reconsideration or appeal made by a member, the member’s representative or Provider, about their experience with WHA, a Medical Group and /or any WHA providers. Grievance is a stage in the appeals process.

"Mental Disorders/Conditions" means disturbances or disorders of mental, emotional, or behavioral functioning, which include the physical symptoms of such disorders regardless of cause or origin. Examples of Mental Conditions include without limitation:

1. *severe mental illness, including, but not limited to: schizophrenia, schizoaffective disorder, bipolar disorder (manic depressive syndrome), major depressive disorders, delusional (paranoid) disorders, psychotic disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, eating disorders, anorexia nervosa and bulimia nervosa; depressive disorders, stress disorders or ailments, anxiety disorders, somatoform disorders (psychosomatic illness), and mental illness; 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).*

The following types of illnesses are excluded from this definition: congenital and/or organic brain disorders, mental retardation, 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, excluding devices to 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.

"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 Pharmacy": A pharmacy under contract with Western Health Advantage, authorized to dispense covered Prescription Medications to Members who are entitled under this Supplement to receive them. A list of all Western Health Advantage Participating Pharmacies is contained in the Western Health Advantage Provider Directory.

"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) 563-2252 or (888) 563-2252.

"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" (PCP) 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 PCP.

"Primary Residence" means one in which the Subscriber and any covered Dependents permanently and physically reside in the residence, no less than 8 continuous months out of the calendar year.

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

"Preferred Brand Name": A list prepared by Western Health Advantage in conjunction with our Participating Physicians which indicates the Brand Name Prescription Medications available under this EOC without prior authorization. The list may be revised periodically, and is distributed to Western Health Advantage Participating Physicians and Participating Pharmacies.

"Preferred Drug List (PDL)" means a listing of medications developed by WHA's Pharmacy and Therapeutics (P & T) Committee as drugs of choice in their respective classes. WHA uses a 3 tier open formulary system. Generic medications listed on the PDL are covered at the lowest co-payment. Brand name medications listed on the PDL are provided at the second co-payment level. Drugs which are not listed on the PDL are covered at the 3rd tier co-payment level but generally do not require a prior authorization. There are a small number of drugs, regardless of tier level that may require Prior Authorization to ensure appropriate use based on criteria set by the WHA Pharmacy and Therapeutics Committee. **Please note: the presence of a drug listed on the WHA PDL, does not guarantee that the member's physician will prescribe the drug.** You may request a copy of the PDL by calling WHA Member Services at (888) 563-2252 or view the document on the web page: www.westernhealth.com**.**

Drugs are evaluated regularly to determine the additions and possible deletions of medications, to ensure rational and cost effective use of pharmaceutical agents through the Pharmacy and Therapeutics (P &T) Committee, which meets every other month. Physicians may request that the P&T Committee consider adding specific medications to the PDL. The Committee reviews all medications for the efficacy, quality, safety, similar alternatives, and cost of the drug in determining the inclusion in the PDL.

"Prescription Medication": A drug which has been approved by the United States Food and Drug Administration and which can, under federal or state law, be dispensed only pursuant to a Prescription order from a physician who is duly licensed to do so.

"Prescription": A written or oral order for a Prescription Medication directly related to the treatment of an illness or injury and which is issued by the attending physician within the scope of his or her professional license.

"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 not for 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 restrict or limit the amount of care which is provided under the benefits of this Combined Evidence of Coverage and Disclosure Form. If a member wants additional information regarding provider compensation issues, the member may request additional information from WHA, the provider or the provider's medical group or IPA.

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

"Seriously Debilitating" means diseases or conditions that cause major irreversible morbidity or sickness.

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

"Structured Outpatient Services" means a structured treatment program consisting of multiple sessions of behavioral health services in each seven (7) day period, with each session no shorter than two (2) hours and no longer than twelve (12) hours in any twenty-four (24) hour consecutive period. Structured Outpatient Services may also be referred to as intensive outpatient treatment, partial hospitalization, or day hospitalization and includes residential treatment programs.

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

"Three Tier Co-Pay Plan": means Generic medications listed on the PDL are covered at the lowest co-payment. Brand name medications listed on the PDL are provided at the second co-payment level. Drugs which are not listed on the PDL are covered at the third (3rd) tier co-payment level, but generally do not require a prior authorization. There are a small number of drugs, regardless of tier level that may require Prior Authorization to ensure appropriate use based on criteria set by the WHA Pharmacy & Therapeutics (P &T) Committee. Members may request a copy of the PDL by calling (888) 563-2252 or view the document on the web page: www.westernhealth.com.

"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 PCP, 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.

WHA SERVICE AREA ZIP CODE LIST

Western El Dorado County:

95613 95614 95619 95623 95633 95634 95635 95636 95651 95664 95656 95667
95672 95675 95682 95684 95709 95726 95762

Placer County:

95602 95603 95604 *__95631 (partial)__ 95648 95650 95658 95661 95663 95677 95678
95681 95703 95713 95722 95736 95746 95747 95765

Sacramento County: All Zip Codes

Solano County:

94512 94533 94535 94571 94585 95620 95625 95687 95688 95694 95696

Yolo County: All Zip Codes

Colusa County:

95912 95931 95932 95950 95955 95957 95987

All subscribers and dependents must live or work within a WHA licensed zip code, meaning that either their primary workplace or primary residence is within a WHA licensed zip code. Subscribers must also fulfill their employers' eligibility requirements.

*Call our Member Services Department at 916-563-2252, to ensure your zip code is covered in our service area.

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WHA

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