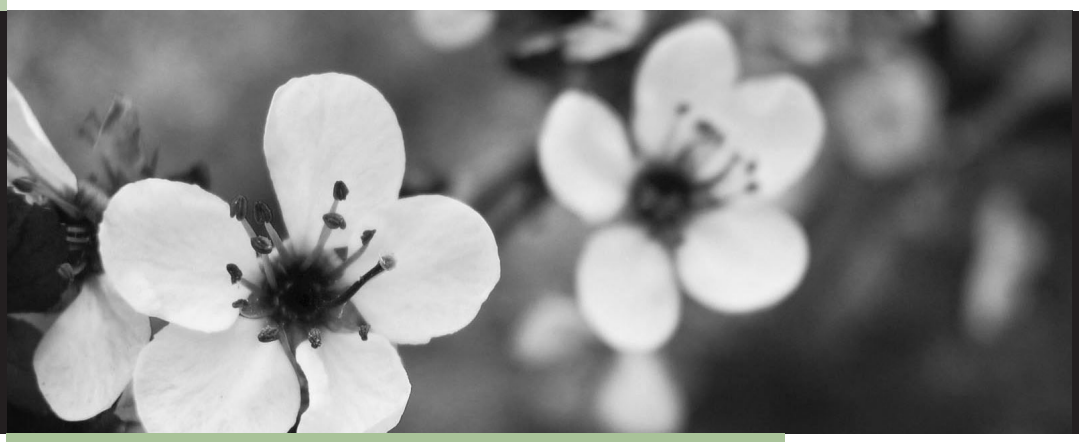
University of California



2011

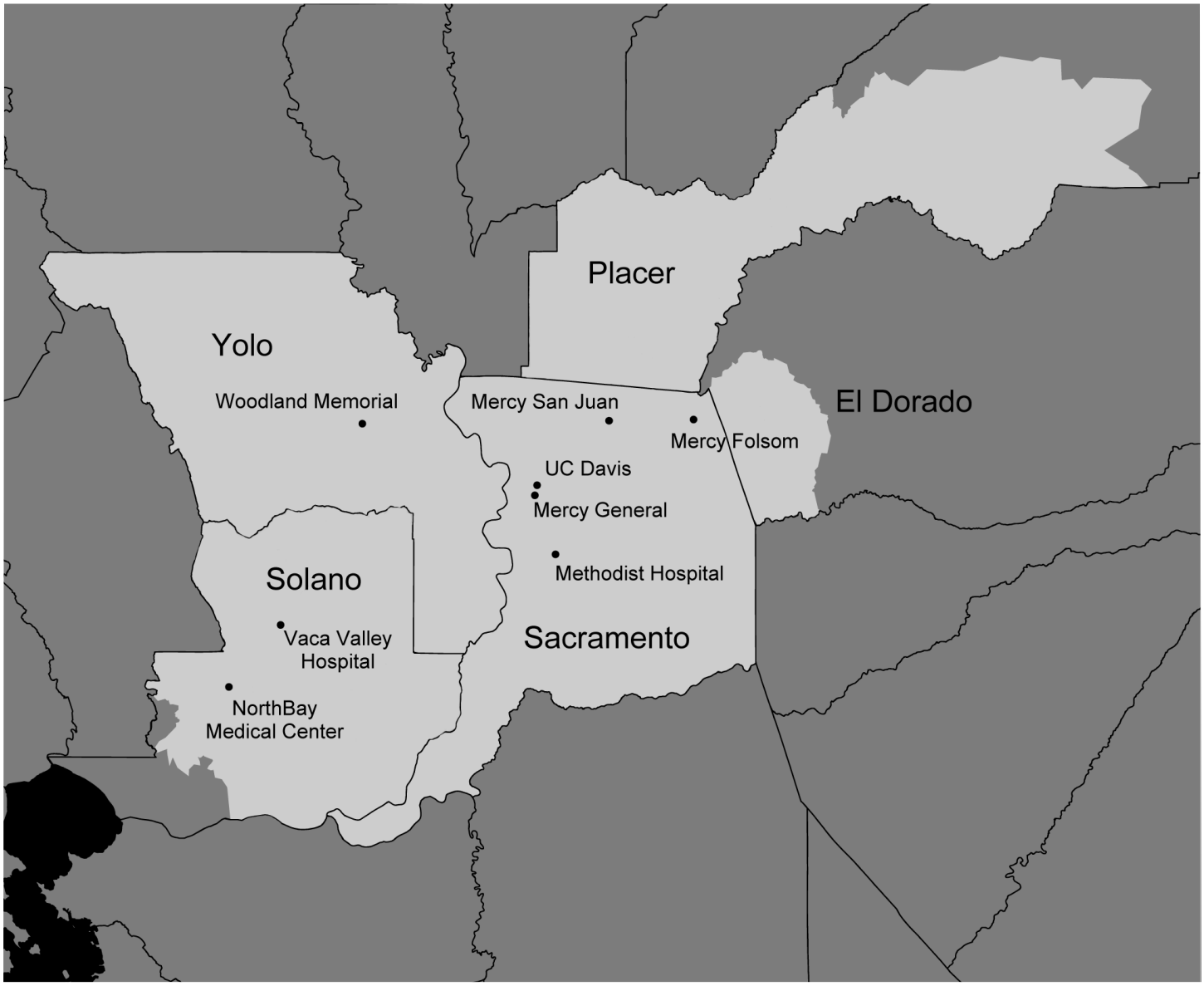
Combined Evidence of Coverage

and Disclosure Form

Western Health Advantage

WHA Service Area Map

With Contracted Hospitals



Western Health Advantage is licensed in the following Zip Codes:

Sacramento	All ZIP Codes
Yolo	All ZIP Codes
Placer	95602 95603 95604 95631 (partial) 95648 95650 95658 95661 95663 95677 95678 95681 95703 95713 95722 95736 95746 95747 95765
Solano	94512 94533 94534 94535 94571 94585 95620 95625 95687 95688 95694 95696
Western El Dorado	95672 95682 95762

Important Information

UC 106A
Group # 00-1021

(To be completed by Member)

Member name _____

Address _____

Telephone number _____

Eligibility date _____

Name of Primary Care Physician _____

Primary Care Physician's address _____

Pharmacy location _____

Pharmacy telephone number _____

24-hour emergency care telephone number _____

Changes for 2011

Please make note of the following changes and/or clarifications to the Combined Evidence of Coverage and Disclosure Form for 2011. This list assists members to identify key changes. It is not intended to be a comprehensive list of changes.

Changes

General Changes throughout the booklet

- Plan effective date changed from January 1, 2010 to January 1, 2011
- Changed "incapacitated" to "disabled"
- Changed "age 23" to "age 26"

Other Changes

Clarified that a Member may choose any of the Primary Care Physicians (PCPs) within WHA's network, as long as the PCP is accepting new patients and has been designated as a PCP; added a rule that Members aged 18 and over must notify WHA of their selection of PCP when changing PCPs – another adult may not do this on their behalf 13

Changed and clarified the rules for when a Member may transfer to another PCP or Medical Group 13

Clarified the policy that Medically Necessary care must be provided in-network when available 14

Expanded the description of services that require Prior Authorization 14

Principal Benefits and Covered Services

Expanded the description of Principal Benefits and Covered Services 20

Added description of preventive services and immunizations that are available at no cost to Members, as required by federal health care reform 20

Added coverage for dental care that is integral to reconstructive surgery for cleft palate 25

Added a description of Case Management Services available to Members who meet certain criteria 26

Added a description of Disease Management Programs available to Members with specific chronic conditions 26

Added a new Nurse Advice Line all Members may call 24 hours a day for information or assistance with medical issues 26

Principal Exclusions and Limitations

Added a statement that there are no annual or lifetime dollar limits on any "essential health benefits", as required by federal health care reform 27

Eligibility, Enrollment and Termination

Changed language on Retiree requirements 30

Added "domestic partner verification" 30

Added "Eligible Adult" as a heading 30

Changed "Social Security" to "Medicare Part A" 31

Changed dependent eligibility provisions due to health care reform 31

Changed language about disabled child's dependency 31

Clarified language in "No Dual Coverage" paragraph 31

Added PIE end date when weekend/holiday for paper forms 32

Changed language about adopted children 32

Clarified PIE when moving out of HMO service area 32

Changed language about premium assistance programs 33

Removed language about spouse 33

Clarified language regarding PIE and retirement 33

Changed language for Retirees in "Effect of Medicare on Enrollment" 33-34

Removed "Medicare Private Contracting Provision" 34

Changed "benefits" to "services" 34

Changed language about deenrollment due to misuse of plan/fraud 34

Clarified that Members who do not live or work in the Service Area are not eligible for continuation or conversion coverage 36, 38

Expanded and clarified the descriptions of reasons that an individual Member's coverage may be terminated 38-40

Plan Administration

Removed language from "Plan Administration" paragraph 41

Clarified language about "Sponsorship and Administration of the Plan" 41

Financial Considerations

Added a disclosure that some physician offices may charge a missed appointment fee if a Member misses an appointment 43

Clarified that both medical and behavioral health expenses accrue to the out-of-pocket maximum liability for Members and/or families 43

Clarified that, when a Member is covered by two plans, the Member is eligible for the number of visits in the plan with the greater benefits 45

Member Satisfaction Procedure

Added a statement that WHA will provide language assistance in non-English languages for the Grievance, Appeal and external review processes 47

Added a statement that when a denial is issued after services have already been approved, coverage for these services will be continued during any Appeal of the denial 47

Added a right of a Member to file an Appeal of any retroactive termination of coverage; coverage may be reinstated if the Appeal is decided in the Member's favor 47

Added a statement that a Member may review WHA's Appeal file and submit testimony, as required under federal health care reform 47

If you have any questions, please feel free to contact our Member Services Department at one of the numbers listed below, Monday through Friday between 8 a.m. and 5 p.m.

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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 health care 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 With Respect to Your PHI."

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 one of the numbers listed below, 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 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:

Attn: Privacy Complaints
Western Health Advantage
2349 Gateway Oaks Drive, 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:

Michael Kruley, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310 phone
(415) 437-8329 fax
(415) 437-8311 TDD

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 one of the numbers listed below.

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 westernhealth.com.

Questions

If you have any questions about this notice or want further information, please contact us at:

Attn: WHA Privacy Officer
Western Health Advantage
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833

Effective Date of this Notice

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

Introduction

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 (EOC/DF) 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. If you want to be sure you have the latest version of the EOC/DF, go to westernhealth.com and sign in through Personal Access to see plan materials for your coverage.

Please read this EOC/DF completely and carefully and keep it handy for reference while you are receiving Medical Services through WHA. It will help you understand how to get the care you need.

This EOC/DF is a summary only of the group health plan. The Group Service Agreement between WHA and your employer that has sponsored your participation in this health plan must be consulted to determine governing contractual provisions as to the exact terms and conditions of coverage. You may request to see the Group Service Agreement from your employer. An applicant has the right to view the EOC/DF prior to enrollment. You may request a copy of the EOC/DF directly from the plan by calling one of the numbers listed below.

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 Service Agreement and this EOC/DF.

This EOC/DF, the Group Service Agreement and benefits are subject to amendment in accordance with the provisions of the Group Service Agreement without the consent or concurrence of Members.

This EOC/DF and the provisions within it are subject to regulatory approval by the Department of Managed Health Care. Modifications of any provisions of this document to conform to any issue raised by the Department of Managed Health Care 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 EOC/DF.

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 EOC/DF.

If you have any questions after reading this EOC/DF or at any other time, please contact Member Services at one of the numbers listed below.

WHA is committed to providing language assistance to Members whose primary language is not English. Qualified interpreters are available at no cost to help you talk with WHA or your doctor's office.

To get help in your language, please call Member Services at the phone numbers below.

Written information, including this EOC/DF and other vital documents, is available in Spanish. Call Member Services to request Spanish-language versions of WHA vital documents.

WHA está comprometido a brindarles asistencia a aquellos miembros cuyo idioma principal no sea el inglés. Tenemos intérpretes calificados sin costo alguno que le pueden ayudar a comunicarse con WHA o con el consultorio de su médico.

Para ayuda en su idioma, por favor llame al Servicio a los Miembros a los números enlistados abajo.

Información escrita, incluyendo este EOC/DF y otros documentos esenciales, está disponible en español. Llame al Departamento de Servicio a los Miembros para solicitar versiones en español de los documentos esenciales de WHA.

Thank you for choosing Western Health Advantage.

Choice of Physicians and Other Providers

Please read the following information so you will know from whom or what group of providers health care may be obtained.

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 and annual vision exams, which may be obtained through direct access without a referral. Your PCP is responsible for coordinating health care you receive from specialists and other medical providers. Referral requirements will be described later in this EOC/DF.

Some hospitals and other providers do not provide one or more of the following services that may be covered under your EOC/DF 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 one of the numbers listed below 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 (4) 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 one of the numbers listed below. To view our online Provider Directory, WHA's website address is westernhealth.com.

Liability of Member for Payment

Copayments

You must pay Copayments for the Covered Services listed in the "Principal Benefits and Covered Services" section of this EOC/DF. Copayments are due when you receive the Covered Service, but for items ordered in advance, you pay the Copayment in effect on the order date. **Note:** WHA will not cover the item unless you still have coverage for it on the date you receive it. See your Copayment Summary for Copayment amounts.

Your Liability for Payment

Our contracts with our Contracted Medical Groups provide that you are not liable for any amounts we owe. However, you may be liable for the cost of non-Covered Services or for services you obtain from non-Participating Providers.

Please refer to the section in this EOC/DF titled "Financial Considerations" for further information.

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 and your annual eye exam, which may be obtained through direct access without a referral. Except as described above or when authorized in advance as described under "How to Use WHA", "Prior Authorization", WHA will not be liable for costs incurred if you seek care from a provider other than your PCP or a Participating Physician to whom your PCP referred you for Covered Services. 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, if 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 "Definitions" for Provider Reimbursement.)

Non-Participating Providers

Any coverage for services provided by a Physician or other health care provider who is not a Participating Provider requires written Prior Authorization before the service is obtained, except in Medically Necessary Urgent Care and Emergency Care situations. If you receive services from a non-Participating Provider without first obtaining Prior Authorization from WHA or your Medical Group, you will be liable to pay the non-Participating Provider for the services you receive.

How to Use WHA

Selecting Your Primary Care Physician

When you enroll in WHA, you must select a Primary Care Physician (PCP) from one of WHA's Medical Groups for yourself and each of your covered Family Members. Each new Member should 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.

You may choose any PCP within the WHA network, as long as that PCP is accepting new patients. If we have not received a PCP selection from you, WHA will assign a PCP to you. The types of PCPs you can choose include:

- pediatricians (for children)*;
- family practice physicians;
- internal medicine physicians (some have a minimum age limit)*;
- general practice physicians; and
- obstetrician/gynecologists*.

***Note:** Not all internal medicine physicians, pediatricians and obstetrician/gynecologists are designated PCPs. Some may practice only as Specialist Physicians. Refer to the WHA Provider Directory or go to westernhealth.com and click on "For Members" and "Search our Provider Directory" for a list of PCPs in your preferred specialty.

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.

For information on how to select a PCP, and for a list of the participating PCPs, call Member Services or go to westernhealth.com and search our online Provider Directory.

Note: Regardless of which Medical Group your PCP is affiliated with, you may be able to receive services from participating specialists in other Medical Groups/IPAs. See "Advantage Referral" below. However, your Medical Group may have rules that require Members in certain areas or assigned to certain PCPs to obtain some ancillary services, such as physical therapy or other services, from particular providers or facilities. For example, selecting a PCP from UC Davis Medical Group does not assure that a Member would have access to UC Davis physical therapy clinics.

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 or 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. **Note:** Generally, Members aged 18 and older are responsible for submitting their own PCP change requests (another adult family member cannot submit the request on their behalf).

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 PCPs or Medical Groups/IPAs as described in this EOC/DF. You may transfer from one to another as follows:

- If your requested PCP is in the same Medical Group as your existing PCP, you may request to transfer to your new PCP effective the first of the following month;
- If your requested PCP is in a different Medical Group than your existing PCP, you may request to transfer to the new PCP effective the first of the following month unless you are confined to a Hospital, in your final trimester of pregnancy, in a surgery follow-up period and not yet released by the surgeon or receiving treatment for an acute illness or injury and the treatment is not complete;
- If you were "auto-assigned" to a PCP and you notify WHA within 45 days of your effective date that you wish to be assigned to a PCP with whom you have a current doctor-patient relationship, and you have not received any services from the auto-assigned Medical Group, you may request to be assigned to the new PCP retroactively to your effective date; or
- When deemed necessary by WHA.

Referrals to Participating Specialists

Advantage Referral

In order to expand the choice of physician specialists for you, WHA implemented a unique program called "Advantage Referral". The Advantage Referral program allows Members to access **most of the Specialist Physicians within WHA's network (listed in the Provider Directory)**, instead of limiting each Member's access to those specialists

who have a direct relationship with the Member's PCP and Medical Group. While your PCP will treat most of your health care needs, if your PCP determines that you require specialty care, your PCP will refer you to an appropriate provider. You may request to be referred to any of the WHA network specialists who participate in the Advantage Referral program. Your WHA Provider Directory designates the providers who do not participate in the Advantage Referral program, or you may call Member Services.

If medically appropriate, your PCP will provide a written referral to your selected participating specialist. Please remember that if you receive care from a participating specialist without first receiving a referral (or if you see a non-participating specialist without Prior Authorization - see "Prior Authorization" below), you may be liable for the cost of those services. You will receive a notification of the details of your referral to a participating specialist 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.

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 and participates in the Advantage Referral program.

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 a standing referral. A standing referral is a referral for more than one visit, to a specialist or "specialty care center" that has demonstrated expertise in treating a medical condition or disease involving a complicated treatment regimen that requires ongoing monitoring. Those specialists designated as having expertise in treating HIV or AIDS are designated with a ‡ in our Provider Directory under their licensed specialty.

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

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. Your doctor or the Physician on call 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.)

Gynecology 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: An annual eye exam from a Participating Provider does not require a referral.

Prior Authorization

Certain Covered Services require Prior Authorization by WHA or its Medical Group in order to be covered. Your PCP must contact the participating Medical Group with which your PCP is affiliated or, in some cases, WHA to request the service or supply be approved for coverage before it is rendered. If Prior Authorization is not obtained, you may be liable for the payment of services or supplies. Requests for Prior Authorization will be denied if the requested services are not Medically Necessary as determined by WHA or the Medical Group, or are requested with a non-Participating Provider and a Participating Provider is available to supply Medically Necessary services for the Member.

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;
- Care with a Specialist Physician that extends beyond an initial number of visits or treatments;
- Physical therapy, speech therapy and occupational therapy;
- Rehabilitative services (cardiac, respiratory, pulmonary);
- All hospitalizations;
- All surgeries;
- Non-emergent medical transport or ambulance care;
- Second medical opinions;
- Some prescription medications (if prescriptions are covered under your plan);
- All infertility services (if infertility services are covered under your plan);
- Scheduled tests and procedures;
- Other services if your Medical Group requires Prior Authorization (ask your PCP); and
- Transgender surgery and related inpatient and outpatient treatments or services.

Requests for Prior Authorization will be authorized or denied within a timeframe appropriate to the nature of the Member's

condition. In non-Urgent situations, a decision will be made within five (5) business days of WHA's or the Medical Group's receipt of the information requested that is reasonably necessary to make the decision. A request for Prior Authorization by a Member, a practitioner on behalf of the Member or a representative for the Member will be reviewed and determined within seventy-two (72) hours of receipt if a later determination could be detrimental to the life or health of the Member, or could jeopardize the Member's ability to regain maximum function, or in the opinion of a physician with knowledge of the Member's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that was requested. If the request for Prior Authorization does not include adequate information for WHA or the Medical Group to make a decision, WHA or the Medical Group will notify the person requesting the Authorization of the needed information and the anticipated date on which a decision may be rendered. Any Prior Authorization is conditioned upon the Member's being enrolled at the time the Covered Services are received. If the Member is not properly enrolled or if coverage has ended at the time the services are received, the Member will be responsible for the cost of the services.

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 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 one of the numbers listed below 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 (1) working day
- Expedited condition – within seventy-two (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 Care.) See the Copayment Summary 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, or call WHA's Nurse Advice Line at (877) 793-3655. Explain your condition to your doctor, the Physician on call at your doctor's office, or the nurse on the Nurse Advice Line and he/she will advise you. In the event you are not able to reach your Physician or the Nurse Advice Line, you may go to an Urgent Care facility affiliated with your Medical Group. For more information about the Nurse Advice Line, please see "Principal Benefits and Covered Services", "Other Health Services".

If you are hospitalized at a non-participating facility because of an Emergency, WHA must be notified within twenty-four (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, make appropriate payment provisions and, if possible, arrange for your transfer back to a Participating Hospital.

Post-Stabilization Care

Once your Emergency Medical Condition is stabilized, your treating health care provider at the hospital emergency room may believe that you require additional post-stabilization services prior to your being safely discharged. If the hospital is a non-Participating Hospital, the hospital will contact your assigned Contracted Medical Group or WHA to obtain timely Prior Authorization for these post-stabilization services. If WHA or its Contracted Medical Group determines that you may be safely transferred to a Participating Hospital and you refuse to consent to the transfer, you will be financially responsible for 100% of the cost of services provided to you at the non-Participating Hospital after your Emergency Medical Condition is stable. Also, if the non-Participating Hospital is unable to determine your name and WHA contact information in order to request Prior Authorization for post-stabilization services, it may lawfully bill you for such services.

If you feel that you were improperly billed for services that you received from a non-Participating Hospital, please contact WHA Member Services.

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 twenty-four (24) hours a day, seven (7) days per week.

Direct Access to Qualified Specialists for Women's Health Services

WHA provides women direct access to Participating Providers – gynecologists, obstetricians, certified nurse midwives, and other qualified health care practitioners. You do not need Prior Authorization from WHA or any other person, including your PCP, in order to obtain access to an OB/GYN who is a Participating Provider. The Participating Provider may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan or following procedures for making referrals. For a list of Participating Providers who are OB/GYNs, please call Member Services or go to westernhealth.com and search our online Provider Directory.

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

In certain circumstances, you may temporarily continue care with a non-Participating Provider. If you are being treated by a provider who has been terminated from WHA's network, or if you are a newly enrolled Member who has been receiving care from a provider not in WHA's network, you may continue care with that provider if you meet the continuity of care criteria explained below. In order for you to be eligible for continued care, the non-Participating Provider must have been treating you for one of the following conditions:

- An acute condition (care continued for the duration of the acute condition).
- A serious chronic condition. A serious chronic condition is a medical condition due to disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure, worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Covered Services will be provided for the period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by WHA in consultation with the Member and the terminated provider or non-Participating Provider, consistent with good professional practice. Completion of Covered Services under this paragraph shall not exceed twelve (12) months from the contract termination date or twelve (12) months from the effective date of coverage for a newly enrolled Member.
- A pregnancy (care continued for the duration of the pregnancy and the immediate postpartum period).
- A terminal illness, an incurable or irreversible condition that has a high probability of causing death within one year (care continued for the duration of the terminal illness).
- Care of a newborn child whose age is between birth and thirty-six (36) months (care continued for a period not to exceed twelve (12) months).
- Performance of surgery or other procedure that has been authorized by WHA or the Medical Group as part of a documented course of treatment that is to occur within one hundred eighty (180) days.

If you are a newly enrolled Member and you had the opportunity to enroll in a health plan with an out-of-network option, or had the option to continue with your previous health plan or provider but instead voluntarily chose to change health plans, you are not eligible for continuity of care.

WHA 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 comply with these contractual terms and conditions, WHA will not continue the provider's services

beyond the contract termination date, and you will not be eligible to continue care with that provider.

WHA and/or the Medical Group will require a non-Participating 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 of similar services who are not capitated and who are practicing in the same or a similar geographic area as the non-Participating Provider, including but not limited to credentialing, hospital privileging, utilization review, peer review and quality assurance requirements. If the non-Participating Provider does not agree to comply or does not comply with these contractual terms and conditions, WHA will not continue the provider's services, and you will not be eligible to continue care with that provider.

Unless otherwise agreed upon by the terminated or non-Participating Provider and WHA or the Medical Group, the services rendered shall be compensated at rates and methods of payment similar to those used by WHA or the Medical Group for currently contracting providers of similar services who are not capitated and who are practicing in the same or a similar geographic area as the terminated or non-Participating Provider. Neither WHA nor the Medical Group is required to continue the services of a terminated or non-Participating Provider if the provider does not accept the payment rates as specified here.

If you believe that your medical condition meets the criteria for continuity of care outlined above, you may be entitled to continue your care with your current provider. Please contact the WHA Member Services Department prior to enrollment, and no later than thirty (30) days from the Effective Date of your WHA coverage or from the date your provider terminated with WHA to request a Continuity of Care form. You also may go to WHA's web page, westernhealth.com, to obtain a copy of the Continuity of Care form. Complete and return this form to WHA as soon as possible. After receiving the completed form, WHA will notify you if you qualify for continuity of care with your provider. If you do qualify for continuity of care, you will be provided with the appropriate plan for your care. If you do not qualify, you will be notified in writing and offered alternative Participating Providers. 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 one of the numbers listed below.

Your Medical Group must preauthorize or coordinate services for continued care. If you have any questions or want to appeal a denial, call our Member Services Department at one of the numbers listed below, Monday through Friday, 8:00 a.m. to 5:00 p.m.

Please note: You should not continue care with a non-Participating Provider without WHA's or your Medical Group's approval. If you do not receive this approval in advance, payment for services performed by a non-Participating Provider will be your responsibility.

Access to Emergency Services

Members have the right to access Emergency 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 and 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 – westernhealth.com.

What Are My Rights?

Member rights may be exercised without regard to age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, health status or the source of payment or utilization of services. Western Health Advantage Member rights include but are not limited to the following:

- To be provided information about WHA's organization and its 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 recognition of your dignity and right to privacy.
- To actively participate with practitioners in making decisions about your health care, 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 to appeal a decision to WHA about the organization or the care it provides, and to expect 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 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 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.

What Are My Responsibilities?

It is the expectation of WHA and its providers that enrollees adhere to the following Member responsibilities to facilitate the provision of high level quality of care and service to Members. Your Member 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 EOC/DF document you received at the time of enrollment and/or that is available on WHA's website at westernhealth.com (log into Personal Access) contains 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 Services Department when a change in residence occurs or other circumstances arise that may effect entitlement to coverage or eligibility.
- To select a 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 preventive health guidelines, prescribed treatment plans and guidelines/instructions that you have agreed to with your health care professionals and to provide to those professionals information relevant to your care.
- 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 Services 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 health care 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 health care 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, provided by one of the following:

- Your PCP;
- A Participating Specialist Physician when referred by your PCP (first three visits need a referral only – more than three visits with a Participating Specialist Physician requires Prior Authorization; see "How to Use WHA", "Prior Authorization");
- Other Participating Providers to whom you have been referred by your PCP;
- Participating or non-Participating Providers who have been authorized by your Medical Group (see "How to Use WHA", "Prior Authorization");
- A participating OB/GYN within your Medical Group, or outside your Medical Group if the OB/GYN participates in Advantage Referral (see "How to Use WHA", "Referrals to Participating Specialists");
- A Participating Provider providing your annual eye exam.

Emergency Care services are covered as described under "How to Use WHA", "Urgent Care and Emergency Care".

You will be responsible for all applicable Copayments as described on your Copayment Summary or in this EOC/DF, 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 EOC/DF.

Outpatient Services

The following outpatient services are covered by WHA. The Copayment Summary defines the Member's Copayment responsibility.

- Office visits for adult and pediatric care, well-baby care, and immunizations;
- Pre-natal and post-natal maternity care;
- Gynecological exams;
- Surgical procedures;
- Periodic physical examinations;
- Office visits for consultations or care by a non-participating specialist when referred and authorized by WHA or your delegated Medical Group;
- Eye examinations (including eye refraction);
- Hearing examinations;
- Laboratory, X-rays, 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;
- Rehabilitative services including physical therapy, speech therapy and occupational therapy, when authorized in advance and determined to be Medically Necessary;
- Short-term respiratory therapy, cardiac rehabilitation and pulmonary rehabilitation, when authorized in advance, determined to be Medically Necessary and determined to lead to continued improvement of the Member's condition;
- Outpatient Transgender Services – Outpatient Services, including outpatient surgery services for transgender surgery, services related to the surgery, outpatient office visits and related services, require Prior Authorization by WHA and are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member. WHA covers certain transgender surgery and services related to the surgery to change a Member's physical characteristics to those of the opposite gender.

Preventive Services and Immunizations: The following preventive services and immunizations are covered with no copayment or cost-sharing when provided by your PCP: evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved (http://www.ahrq.gov/clinic/pocketgd09/gcp09s1.htm); immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5515a1.htm); and with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources Services Administration.

Preventive Services covered by WHA at no cost are listed in Appendix A. Immunizations covered by WHA at no cost are listed on the Centers for Disease Control website referenced above. In order for an office visit to be considered "preventive", the service must have been provided or ordered by your PCP, or an OB/GYN who is a Participating Physician within your Medical Group or participating in Advantage Referral, and the primary purpose of the office visit must have been to obtain the preventive service. WHA and its Medical Groups may impose reasonable medical management techniques to determine the frequency, method, treatment or setting for a preventive service or item unless the particular

guideline itself specifies otherwise. WHA does not cover any medications or supplements that are generally available over the counter, even if the Member has received a Prescription for the medications or supplements. Your plan may provide additional preventive services at no cost to you; consult your Copayment Summary for more information.

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 a human papillomavirus screening test that is approved by the federal Food and Drug Administration; 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. Cancer screening is 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 determining that such participation may potentially provide a benefit to the Member.

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

1) Drugs or devices associated with the clinical trial that have not been approved by the FDA;

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 participation in the clinical trial;

3) Any item or service 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, please contact WHA's Member Services Department.

Inpatient Services

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

The following inpatient services are covered by WHA. The Copayment Summary defines the Member's Copayment responsibility.

- Semi-private room and board (private room when determined to be Medically Necessary by a Participating Provider);
- Physician's services including surgeons, anesthesiologists and medical consultants;
- Hospital specialty services including the use of the operating room and the 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;
- Rehabilitative services including physical therapy, speech therapy and occupational therapy, if required incident to an admission for Covered Services and determined to be Medically Necessary.
- Short-term respiratory therapy, cardiac rehabilitation and pulmonary rehabilitation, if required incident to an admission for Covered Services, determined to be Medically Necessary and determined to lead to continued improvement of the Member's condition.

Inpatient Transgender Surgery: Inpatient transgender surgery requires Prior Authorization from WHA. Transgender surgery and services related to the surgery that are authorized by WHA are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member. WHA covers certain transgender surgery and services related to the surgery to change a Member's physical characteristics to those of the opposite gender.

Travel expense reimbursement is limited to reasonable expenses for transportation, meals and lodging for the Member to obtain authorized surgical consultation, transgender reassignment surgical procedure(s) and follow-up care, when the authorized surgeon and facility are located more than 200 miles from the Member's Primary Residence. The transportation and lodging arrangements must be arranged by or approved in advance by WHA. Reimbursement excludes coverage for alcohol and tobacco. Food and housing expenses are not covered for any day a Member is not receiving authorized transgender reassignment services. Travel expenses are included in the $75,000 lifetime benefit maximum.

Behavioral Health Services

Behavioral health services, including chemical dependency services, are not covered by WHA. They are covered through United Behavioral Health (UBH), the supplemental coverage provided by your employer. You may reach UBH at (888) 440-8225.

Behavioral health benefits are to be provided at the same level, including any Deductibles and Copayments, as WHA provides for all medical conditions.

Prescription Medication Benefit

WHA shall cover Prescription Medications at Participating Pharmacies, prescribed in connection with a Covered Service, subject to conditions, limitations and exclusions stated in this EOC/DF.

Prescription drugs prescribed by a Participating Provider and obtained at a Participating Pharmacy will be dispensed for up to a 30-day supply, except as set forth in the section below titled "Mail Order and UC Medical Center Prescriptions – Maintenance Medications". Copayments for covered medications are described in the Copayment Summary.

If a Brand Name Medication is dispensed at the request of the Physician or Member when a Generic Medication is available, the Member will pay the Preferred Generic Medication Copayment plus the difference in cost between the Generic Medication and the Brand Name Medication. If there is no Generic Medication equivalent, the Preferred Brand Name or Non-Preferred Medication Copayment applies.

Prescription Copayments do not contribute to the medical annual out-of-pocket maximum (unless required for diabetes supplies or pediatric asthma supplies and equipment).

At walk-in pharmacies if the actual cost of the Prescription is less than the applicable Copayment, the Member will only be responsible to pay the actual cost of the medication.

Preferred Drug List

WHA uses a Preferred Drug List and a Three-Tier Copayment Plan, rather than a closed formulary. The three tiers are: Tier 1 – Preferred Generic Medications, Tier 2 – Preferred Brand Name Medications and Tier 3 – Non-Preferred Medications. Preferred Generic Medications are covered at the lowest Copayment level. Preferred Brand Name Medications are provided at the second Copayment level and drugs not listed on the PDL (Non-Preferred) are covered at the third tier Copayment level. 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 (P&T) Committee. Please note that a drug's presence on the WHA PDL does not guarantee that the Member's Physician will prescribe the drug. Members may request a copy of the PDL by calling one of the numbers listed below or view the document on our web site, westernhealth.com.

Drugs are evaluated regularly, to determine the additions to and possible deletions from the PDL, and to ensure rational and cost-effective use of pharmaceutical agents, through the 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.

Mail Order and UC Medical Center Prescriptions – Maintenance Medications

Covered Prescription Medications that are to be taken beyond sixty (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. Maintenance Medications may be obtained by mail order through Medco Health, WHA's prescription benefit manager. Oral contraceptives are also available through the mail order program. You can request the order form and brochure for this benefit by contacting Medco Health Customer Service at (800) 903-8664, 24 hours a day, 7 days a week (except Thanksgiving and Christmas) or online at medcohealth.com.

Maintenance Medications may also be obtained from the UC Medical Center Pharmacy for up to a 90-day supply, as described in the Copayment Summary.

Covered Prescription Medications

- Oral medications that require a Prescription by state or federal law, written by a Participating Physician and dispensed by a Participating Pharmacy.
- Covered Prescription Medications dispensed by a non-Participating Pharmacy outside of WHA's Service Area for Urgent or Emergency Care only. You may submit your receipt to Medco Health for reimbursement.
- Insulin and insulin syringes with needles, glucose test strips and tablets.
- Oral contraceptives and diaphragms.
- Oral medications and injectables for the treatment of Infertility and Erectile Dysfunction require Copayments equal to 50% of the contracted Prescription cost.

Pharmacy Principal Exclusions and Limitations

The covered Prescription Medications are subject to the exclusions and limitations described in this section:

1) Generic Medications are required. The pharmacist will automatically substitute an equivalent Generic Medication for the prescribed Brand Name Medication (Preferred or Non-Preferred) unless: your Physician writes, "do not substitute" or "prescribe as written"; there is not a Generic equivalent available; or the medication is included in the list of Narrow Therapeutic Index (NTI) drugs that currently have potential equivalency issues. In these cases, the Member will be provided the Brand Name Medication as written by the Member's Physician, even if a Generic is available. The Member will pay the Preferred Generic Medication Copayment plus the difference in cost between the Generic Medication and the Brand Name Medication. A Member may request a list of applicable NTI drugs by calling WHA Member Services at one of the numbers listed below.

2) Some Prescription Medications may require Prior Authorization by WHA. For clarification, please contact WHA Member Services at one of the numbers listed below. Routine/non-urgent requests for Prior Authorization are processed within three business days if all applicable information is included with the request. Requests that are indicated as urgent will be reviewed within one business day. An incomplete request may delay the authorization process if the provider is not available to supply the necessary clinical information. For a Prior Authorization request after business hours, or on weekends and holidays in an urgent or emergency situation, the Pharmacy is authorized to dispense an emergency short supply of the medication.

3) Covered Prescription Medications are limited to a 30-day supply at a Participating Pharmacy. A 90-day supply of oral Maintenance Medications is available through WHA's Mail Order program (see below). Oral specialty medications that cost over $500 for a 30-day supply are limited to a 30-day supply.

4) Covered Prescription Medications that are to be taken beyond sixty (60) days are considered Maintenance Medications and may be obtained through the Mail Order Program or the UC Medical Center pharmacy. 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 or the UC Medical Center pharmacy.

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 WHA for review. Drugs and medications are limited to eight (8) pills per 30-day period, and are subject to a 50% Copayment.

8) Medications that are experimental or investigational are excluded, except for Life-Threatening or Seriously Debilitating conditions and cancer clinical trials as described in this EOC/DF, under the section titled "Independent Medical Review of Investigational/ Experimental Treatment".

9) There are a small number of drugs, regardless of PDL tier level, that may require Prior Authorization for a non-FDA-approved indication (off label use). For off label use, the medication must be FDA-approved for some indication and recognized by the American Hospital Formulary Service Drug Information or one of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: The Elsevier Gold Standard's Clinical Pharmacology, the National Comprehensive Cancer Network Drug and Biologics Compendium or The Thomson Micromedex DrugDex, or at least two articles from major peer-reviewed medical journals that present data supporting the proposed use as safe and effective, unless there is clear and convincing contradictory evidence in a similar journal.

10) Prescriptions written by dentists are excluded.

11) Drugs required for foreign travel are excluded, unless they are prior authorized for Medical Necessity.

12) Prescription products for cosmetic indications, including agents for wrinkles or hair growth, and over-the-counter dietary/nutritional aids and health/beauty aids are excluded.

13) Drugs used for weight loss and/or dietary/nutritional aids which require a Prescription are excluded, unless they are prior authorized for Medical Necessity.

14) Contraceptive devices (including IUD's) and implantable contraceptives are not covered under the pharmacy benefit; they are covered under the medical benefit as described in this EOC/DF.

15) Medication for injection or implantation (except insulin and other medications as determined by WHA) are covered under the medical benefit as described in the EOC/DF under the sections titled "Outpatient Services" and "Other Health Services".

16) Pharmacies which dispense covered Prescription Medications to Members pursuant to an agreement with WHA or its pharmacy benefit manager and this pharmacy benefit, do so as independent contractors. WHA 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.

17) WHA 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.

18) Vitamins (except prenatal prescription vitamins or vitamins in conjunction with fluoride) are excluded.

19) Medications for the treatment of short stature are excluded, unless Medically Necessary.

20) Replacement medications for drugs that are lost or stolen are not covered.

Submitting Prescription Claims for Reimbursement. If a Member pays for a covered Prescription Medication as described in this EOC/DF, the original receipt along with a copy of Member's identification card, address, a daytime telephone number, and the reason for the reimbursement request should be submitted to Medco Health, WHA's

pharmacy benefit manager, within sixty (60) days of purchase. No claim will be considered if submitted beyond twelve (12) months from the date of purchase.

Prescription claims under the Plan are processed by Medco Health. You can order claim forms online at www.medcohealth.com or by calling Medco Health Member Services at (800) 903-8664.

Infertility Services

Covered Infertility services generally include consultations, examinations, diagnostic services whether performed in a Physician's office or in a hospital or other facility, and medications. All covered Infertility services, including the diagnostic work-up and testing to establish a cause of "Infertility", require a 50% Copayment, which is based on WHA's contracted Charges. All covered Infertility services must receive Prior Authorization and are subject to the exclusions and limitations set forth in this EOC/DF. Copayments for covered Infertility services do not contribute to the annual out-of-pocket maximum.

"Infertility" is defined as a condition of being pre-menopausal with either: (1) the presence of a condition recognized by the Physician as a cause of infertility, or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after one year or more of **regular** sexual relations without contraception. In order to be eligible for covered Infertility services, the Member must be diagnosed with "Infertility" as defined above.

We cover the following services:

- Services and supplies for diagnosis and treatment of involuntary infertility;
- 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;*
- Medications for the treatment of Infertility.

Genetic testing and counseling are covered benefits when medically indicated and are not subject to the Infertility Benefit Copayments.

*"Lifetime" refers to services obtained during the Member's life, including services provided under any other health insurance or HMO.

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 Intrafallopian 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 in connection with the reversal of voluntary sterilization and infertility treatment after reversal attempts.

Other Health Services

Home Health Care Services, short-term intermittent care, up to one hundred (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 is covered when you have met the Hospice Care requirements:

1) A Participating Physician has diagnosed you with a terminal illness and certifies, in writing, that your life expectancy is one (1) year or less;
2) A Participating Physician authorizes the services;
3) A Participating Physician has written a plan of care;
4) The Hospice Care team approves the care;
5) The services are to be provided by a licensed Hospice agency approved by WHA or the Medical Group;
6) The services are Medically Necessary for palliation or management of the terminal illness; and
7) You elect Hospice Care in writing.

If all of these requirements are met, you may choose 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 EOC/DF. You may change your decision about Hospice Care at any time. 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 the above requirements are met:

- Participating Physician services.
- Skilled nursing services.
- Physical, occupational or respiratory therapy, or therapy for speech-language pathology.
- Medical social services.

- Home health aide and homemaker services.
- Palliative drugs prescribed for pain control and symptom management of the terminal illness in accordance with our drug formulary and Plan guidelines, obtained from a contracting Plan pharmacy.
- Durable Medical Equipment in accordance with Plan guidelines.
- Short-term inpatient care including respite care, care for pain control and acute and chronic symptom management.
- Counseling and bereavement services.

Skilled Nursing Facility, short-term care to a maximum of one hundred (100) days in each calendar year is covered if Medically Necessary.

Durable Medical Equipment (DME), Prosthetic Devices and Orthotic Devices when prescribed by a Participating Provider and determined to be Medically Necessary, covered at a Copayment set forth in the Copayment Summary. Examples of DME include: standard wheelchair, oxygen and oxygen equipment. Orthotic Devices include special footwear that is Medically Necessary as a result of foot disfigurement that arises out of cerebral palsy, arthritis, polio, spina bifida, diabetes and accidental or developmental disabilities. See the "Definitions" section for definitions of covered Orthotic and Prosthetic Devices.

- WHA may, in its sole discretion, determine whether the covered device should be purchased or rented and directly order or coordinate the ordering of the covered device.
- 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.
- Where two or more alternative covered devices are appropriate to treat the Member's condition, the most cost-effective device will be covered.
- Coverage for devices is limited to the basic type of DME, Prosthetic Device or Orthotic Device that WHA determines to be necessary to provide for the Member's medical needs.
- The allowable cost of covered devices will not be applied toward similar services and supplies that are not covered devices.

Reconstructive Surgery is covered to improve function or to create a normal appearance, to the extent possible, or to repair "abnormal structures" of the body that are caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. Dental care that is integral to resconstructive surgery for cleft palate is covered.

WHA covers certain transgender surgery and services related to the surgery to change a Member's physical characteristics to those of the opposite gender. Inpatient and Outpatient Services for transgender surgery and services related to the surgery require Prior Authorization by WHA and are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member.

Mastectomy and Reconstructive Breast Surgery to restore and achieve symmetry is covered in full. Coverage for a mastectomy includes coverage for all complications from a mastectomy. This includes 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 areola reconstruction and the insertion of a breast implant. Reconstructive surgery for a healthy breast is also covered if, in the opinion of the attending Physician, this surgery is necessary to achieve normal symmetrical appearance. The attending Physician, consistent with sound clinical practice and in consultation with the patient, will determine the length of the hospital stay for mastectomies and lymph node dissections.

Testing and treatment of PKU includes formula and special food products that are prescribed and are Medically Necessary for treatment of PKU.

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.

Diabetes supplies, equipment, and services for the treatment and/or control of diabetes are covered. Services include outpatient self-management training education and medical nutrition therapy for the treatment and/or control of diabetes necessary to enable you to properly use the equipment, supplies, and medications upon the direction or prescription of those services by your Participating Physician. The following equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin using diabetes, and gestational diabetes are also covered as Medically Necessary, even if the items are available without a Prescription:

- Blood glucose monitors and blood glucose testing strips.
- Blood glucose monitors designed to assist the visually impaired.
- Insulin pumps and all related necessary supplies.
- Ketone urine testing strips.
- Lancets and lancet puncture devices.
- Pen delivery systems for the administration of insulin.

- Podiatric devices to prevent or treat diabetes-related complications.
- Insulin syringes.
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

Pediatric Asthma supplies, equipment, and services when Medically Necessary for the management and treatment of pediatric asthma, including outpatient self-management training education to enable you to properly use the equipment, supplies and medications upon the direction or prescription of those services by your Participating Physician. The following equipment and supplies for the management and treatment of pediatric asthma are covered as Medically Necessary, even if the items are available without a prescription:

- Nebulizers, including face masks and tubing.
- Inhaler spacers.
- Peak flow meters.

Hearing aids are covered at a 50% Copayment with a $2,000 benefit maximum; limited to one device per ear every thirty-six (36) months.

Emergency medical transport services are covered when ordered by a Participating Provider and determined to be Medically Necessary. If a Member reasonably believes he/she is having an emergency, the Member should call "911". Ambulance services are covered if the Member reasonably believes he or she is in an emergency situation.

Case Management (CM) services are available to any Member meeting program criteria. Typically, CM services are provided to Members with complex or multiple medical conditions that require many visits to specialists, and to Members who require multiple services. If you need help managing your health care needs, you, a PCP, relative or anyone else acting on your behalf can make a referral to your Medical Group asking for case management assistance. Case managers are experienced nurses who personally help you through the complexities of the health care system to make sure you get the care you need under your insurance. You may ask your PCP to send a case management referral for you or you may call your Medical Group, yourself. For more details, visit our website at westernhealth.com.

Disease Management (DM) programs are a covered benefit to Members living with specific chronic conditions. WHA contracts with Alere®, a National Committee for Quality Assurance (NCQA) accredited DM provider to administer the programs and perform oversight activities. Currently, the following DM programs are available to qualifying participants:

- Asthma Program for Members aged 5-56;
- Cardiac Disease Program for Members 18 years and older;
- Diabetes Program for Members 18 years and older.

For additional information regarding the programs, please contact WHA's Member Services Department or visit our website at westernhealth.com.

Nurse Advice Line (Nurse24). WHA offers all Members around-the-clock access to registered nurses who help answer questions about a medical problem they may have, including:

- Caring for minor injuries and illnesses at home;
- Seeking the most appropriate help based on the medical concern;
- Identifying and addressing emergency medical concerns.

They can also help you get the appropriate care you need with the right WHA health care providers. Nurse24 services are available 24 hours a day, seven days a week by calling (877) 793-3655.

Principal Exclusions and Limitations

Lifetime and Annual Dollar Limits: There are no lifetime or annual dollar limits on any essential health benefits. All dollar limits, if any, are specified in this EOC/DF or the Copayment Summary. WHA has no pre-existing condition exclusions for any Subscriber or Dependent.

The following services and supplies are excluded or limited:

Exclusions

1) Any services or supplies obtained before the Member's effective date of coverage.

2) Services and supplies which are not Medically Necessary. If a service is denied or is not covered based on Medical Necessity, a Member may appeal the decision through the Independent Medical Review (IMR) process found in the section of this EOC/DF titled "Independent Medical Review" under "Member Satisfaction Procedure".

3) Non-emergent services and supplies rendered by non-Participating Providers without written referral by the Member's PCP, and any service for which a PCP referral or Prior Authorization is required as described in this EOC/DF or any rider. Prior Authorization and care by non-Participating Providers will only be provided as a Covered Service if the care is determined to be Medically Necessary and not available through Participating Providers.

4) Experimental medical or surgical procedures, services or supplies. Please refer to the section of this EOC/DF titled "Independent Medical Review of Investigational/Experimental Treatments" under "Member Satisfaction Procedure".

5) Long term care benefits including skilled nursing care and respite care, except for Medically Necessary Covered Services described in the "Other Health Services", "Hospice Care" under the "Principal Benefits and Covered Services" section.

6) Cosmetic services and supplies, except for Prosthetic Devices incident to a mastectomy or laryngectomy or reconstructive surgery necessary to repair a functional disorder as a result of disease, injury or congenital anomaly, or to improve function and/or create a normal appearance to the extent possible. 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; and chemical face peels or abrasions of the skin.

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

8) Non-emergent medical transport or ambulance care inside or outside the Service Area, except with Prior Authorization.

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

10) Hearing aid batteries.

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

12) 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, (2) when integral to reconstructive surgery for cleft palate or (3) 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:

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

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

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

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

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

16) Routine foot care (e.g., treatment of or to the feet for corns or calluses), except when Medically Necessary. Orthotic Devices for routine foot care are also excluded. This exclusion does not apply to special footwear required as a result of foot disfigurement caused by diabetes.

17) All immunizations required by an employer as a condition of employment.

18) 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. This exclusion does not apply to Covered Services included in the Hospice benefit described under the "Principal Benefits and Covered Services" section of this EOC/DF.

19) Non-prescription weight loss aids and programs and non-Participating Provider programs.

20) Smoking cessation products and programs other than as specifically listed in Appendix A.

21) 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.

22) Food supplements or infant formulas, except in the treatment of PKU.

23) Over-the-counter medications, supplies or equipment that may be obtained without a Prescription, except for diabetes and pediatric asthma supplies as described under the headings "Diabetes supplies, equipment and services" and "Pediatric Asthma supplies, equipment, and services".

24) Services and supplies associated with the donation of organs when the recipient is not a Member of WHA. Medically Necessary services for the treatment of organ transplants when the Member is the organ recipient are covered (see "Transplants").

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

26) Travel expenses, including room and board, even if the purpose is to obtain a Covered Service, except for Transgender Surgery (see "Inpatient Transgender Surgery" for limitations).

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

28) Weight control surgery or procedures including without limitation gastric bubble, gastroplasty, gastric bypass, gastric stapling, liposuction and 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 Prior Authorization are covered.

29) Testing for the sole purpose of determining paternity.

30) Diagnostic procedures or testing for genetic disorders, except for prenatal diagnosis of fetal genetic disorders in cases of high-risk pregnancy or when medically indicated.

31) Diagnosis and treatment for personal growth and/or development, for personality reorganization or in conjunction with professional certification.

32) Ancillary services such as Vocational Rehabilitation, behavioral training, sleep therapy, employment counseling, training or education therapy for learning disabilities or other Educational Services.

33) Behavioral health services, including chemical dependency services, are not covered by WHA. They are covered through United Behavioral Health (UBH), the supplemental coverage provided by your employer.

34) Treatment of short stature unless treatment is Medically Necessary.

35) Exclusions related to transgender surgery services:

    a) Liposuction to reshape waist, hips, thighs and buttocks.

    b) Cosmetic chest reconstruction or augmentation mammoplasty.

    c) Electrolysis and laser hair removal, except when required as part of covered transgender genital reconstruction surgery.

    d) Drugs for hair loss or growth.

    e) Voice therapy or voice modification surgery.

    f) Sperm or gamete procurement for future infertility or storage of sperm, gametes or embryos.

    g) Penile implant devices, penile device implantation and penile implant revision or reinsertion.

    h) Intersex surgery (transsexual operations) except as specifically provided under the "Inpatient Transgender Surgery" and "Outpatient Transgender Services" sections of the "Principal Benefits and Covered Services" section, or treatment of any resulting complications, unless that treatment is determined to be Medically Necessary.

36) All services involved in surrogacy, including but not limited to embryo transfers, services and supplies related to donor sperm or sperm preservation for artificial insemination. Surrogacy is pregnancy under a surrogate arrangement. A surrogate pregnancy is one in which a woman (the surrogate) has agreed to become pregnant with the intention of surrendering custody of the child to another person. If the surrogate is a Member of WHA, she is entitled to maternity services, but in the event pregnancy services are rendered to a woman in a surrogate arrangement, the Plan or its Medical Group has the right to impose a lien against any amount received by the surrogate/Member for reasonable costs incurred by WHA or its contracted Medical Groups.

37) Home birth delivery.

38) Services and supplies in connection with the reversal of voluntary sterilization and infertility treatment after reversal attempts.

39) In Vitro fertilization (IVF).

40) Gamete Intrafallopian Transfer (GIFT).

41) Frozen embryo transfers and Zygote Intra-Fallopian Transfer (ZIFT).

42) Intracytoplasmic Sperm Injection (ICSI).

43) Ova sticks (a self-test for infertility).

44) Ovum transfer/transplants or uterine lavage as part of infertility diagnosis or treatment.

45) All services related to the sperm donor, including the collection of the sperm.

46) Sperm storage.

47) Infertility services required as a result of a woman's partner's elective vasectomy or a woman's elective tubal ligation.

48) Artificial insemination in the absence of a diagnosis of Infertility.

49) Treatment of female sterility in which a donor ovum would be necessary (e.g., post-menopausal syndrome).

50) Experimental and/or investigational diagnostic studies, procedures or drugs used to treat or determine the cause of infertility.

51) Laboratory medical procedures involving the freezing or storing of sperm, ovum and/or pre-embryos.

52) Inoculation of a woman with her partner's white cells (considered experimental).

53) Acupuncture and chiropractic care, acupressure, biofeedback, sex therapy, dance therapy and recreational therapy.

Limitations

All benefits for Covered Services are provided in connection with determining Medical Necessity. The services and supplies used to diagnose and treat any disease, illness or injury must be used 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 care from the non-Participating Provider has been authorized in advance.

2) Respiratory therapy, cardiac rehabilitation and pulmonary rehabilitation are limited to short-term rehabilitative services that are authorized in advance, determined to be Medically Necessary and determined to lead to continued improvement of the Member's condition. Therapy and rehabilitation are not covered when:

   a) medical documentation does not support the Medical Necessity because of the Member's inability to progress toward the treatment plan goals; or

   b) a Member has already met the treatment plan goals.

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 receive benefits from another health plan or collect damages due to a third party's liability, including Workers' Compensation, the Member is required to assist in the assignment, liens and recovery of any WHA expense. WHA and/or the Medical Group may file a lien on any proceeds received by a Member for any expense incurred by WHA or its Medical Group, respectively. Members not legally required to be covered by Workers' Compensation benefits are eligible for twenty-four (24) hour coverage under WHA. See "Third Party Responsibility – Subrogation".

5) WHA will not be held liable for the lack of available services in the event of a major disaster, epidemic, war, riot or other like circumstance 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. If the Plan is unable to provide services it will refer Members to the nearest hospital for Emergency Services and later provide reimbursement to the Member for such Covered Services.

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 are not covered unless determined to be Medically Necessary and authorized by WHA.

8) WHA covers certain transgender surgery and services related to the surgery to change a Member's physical characteristics to those of the opposite gender. Inpatient and Outpatient Services for transgender surgery require Prior Authorization by WHA and are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member.

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 this EOC/DF. 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 the WHA Plan. If the Plan is a Health Maintenance Organization (HMO) 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 or enrolled in a non-University Medicare Part D Prescription Drug Plan will be deenrolled from this health plan. Employees enrolled in this plan at time of retirement who are eligible to continue UC medical coverage will be able to continue enrollment in this Plan into retirement until the Retiree or the Retiree's family member becomes eligible for Medicare. See "Effect of Medicare on Enrollment" below. Once Medicare eligibility is attained by a Retiree or any Family Member, the Retiree is required to change to another University medical 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 "WHA Service Area Map" and zip code listing at the beginning of this EOC/DF.

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.

**Average Regular Paid Time – For any month, the average number of regular paid hours per week (excluding overtime, stipend or bonus time) worked in the preceding twelve (12) month period. Average regular paid time does not include full or partial months of zero paid hours when an Employee works less than 43.75% of the regular paid hours available in the month due to furlough, leave without pay or initial employment.

Subscriber Retiree

A **Retiree** is a former University Employee 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 provided that you also meet the following requirements:

1) You meet the University's service credit requirements for Retiree medical eligibility;

2) The effective date of your Retiree status is within 120 calendar days of the date employment ends; and

3) You elect to continue (or effective 1/1/05 suspend) medical coverage at the time of retirement.

A **Survivor** – a deceased Employee's or Retiree's Family Member receiving monthly benefits from a University-sponsored defined benefit plan – may be eligible to continue coverage as set forth in the University's Group Insurance Regulations. For more information, see the UC *Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members* or the *Survivor and Beneficiary Handbook*.

If you are eligible for Medicare, you must follow UC's Medicare Rules. See "Effect of Medicare on 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 WHA 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), domestic partner verification, adoption records, federal Income Tax Return, or other official documentation.

Eligible Adult

Spouse: Your legal spouse.

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

Opposite-Sex Domestic Partner: The University recognizes 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.

Note: An adult dependent relative is no longer eligible for coverage. Only an adult dependent relative who was enrolled

as an eligible dependent as of December 31, 2003 and continues to be ineligible for Medicare Part A may continue coverage in UC-sponsored plans.

Child

All eligible children must be under the limiting age of 26 (18 for legal wards) except for a child who is incapable of self-support due to a physical or mentally disabling injury, illness or condition. The following categories are eligible:

- Your natural or legally adopted children;
- Your spouse's natural or legally adopted children (your stepchildren);
- Your eligible domestic partner's natural or legally adopted children;
- Grandchildren of you, your spouse or your eligible domestic partner if unmarried, living with you, dependent on you, your spouse or your eligible domestic partner for at least 50% of their support and are your, your spouse's or your eligible domestic partner's dependents for income tax purposes;
- Children for whom you are the legal guardian if unmarried, living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes;
- Children for whom you are legally required to provide group health insurance pursuant to an administrative or court order. (Child must also meet UC eligibility requirements.)

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental disability may continue to be covered past age 26 provided:

1) The plan-certified disability began before age 26, the child was enrolled in a UC group medical plan before age 26 and coverage is continuous;
2) The child is chiefly dependent upon you, your spouse or your eligible domestic partner for support and maintenance; unmarried and
3) The child is claimed as your, your spouse's or your eligible domestic partner's dependent for income tax purposes or, if not claimed as such dependent for income tax purposes, 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.

Application for coverage beyond age 26 due to disability must be made to WHA sixty days prior to the date coverage is to end due to reaching limiting age. If application is received timely but WHA does not complete determination of the child's continuing eligibility by the date the child reaches WHA's upper age limit, the child will remain covered pending WHA's determination. WHA may periodically request proof of continued disability, but not more than once a year after the initial certification. Disabled 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; however, the new plan may require proof of continued disability, but not more than once a year.

If you are a newly hired Employee with a disabled child over age 26 or if you newly acquire a disabled child over age 26 (through marriage or adoption), you may also apply for coverage for that child. The child's disability must have begun prior to the child turning 26. Additionally, the child must have had continuous group medical coverage since age 26, and you must apply for University coverage during your Period of Initial Eligibility. WHA will ask for proof of continued disability, but not more than once a year after the initial certification.

Important Note: Health and welfare benefits and eligibility requirements, including dependent eligibility requirements are subject to change (e.g., for compliance with applicable laws and regulations). UC dependent eligibility requirements may change following final health care reform legislation, regulatory guidance or other applicable laws.

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. If an Employee and the Employee's spouse or domestic partner are both eligible Subscribers, each may enroll separately or one may enroll and 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.

More Information

For information on who qualifies and how to enroll, contact your local Benefits Office or the University of California's (UC) Customer Service Center at (800) 888-8267. You may also access eligibility fact sheets on UC's *At Your Service* web site: http://atyourservice.ucop.edu.

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 UC Customer Service Center. Enrollment transactions may be completed in 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 UC Customer Service Center by the last business day within the applicable enrollment period. Electronic

transactions must be completed by the deadline of the last day of the enrollment period.

During a Period of Initial Eligibility (PIE)

A PIE begins the day you become eligible and ends 31 days after it began (but see exception under "Special Circumstances" paragraph 1.d. below). Also see "At Other Times for Employees and Retirees" below. If the last day of a PIE falls on a weekend or holiday, the PIE is extended to the following business day when enrolling with forms.

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 in which you are enrolled.

1) For a spouse, on the date of marriage.

2) For a Domestic Partner, on the date the domestic partnership is legally established. Also see "At Other Times for Employees and Retirees" below.

3) For a natural child, on the child's date of birth.

4) For an adopted child, the earlier of:

    a) The date the child is placed for adoption with the Employee/Retiree, or

    b) The date the Employee/Retiree or Spouse/Domestic Partner has the legal right to control the child's health care.

    A child is "placed for adoption" with the Employee/Retiree as of the date the Employee/Retiree assumes and retains a legal obligation for the child's total or partial support in anticipation of the child's adoption.

    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.

5) Where there is more than one eligibility requirement, the date all requirements are satisfied.

If you are in an Health Maintenance Organization (HMO), Exclusive Provider Organization (EPO) or Point of Service (POS) 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 available in the new location. Your PIE starts with the effective date of the move or the date you leave the Plan's Service Area. Upon return to the Service Area, you will have a PIE to reenroll yourself and eligible Family Members in the same HMO, EPO or POS you had at the time of the move out of the area. The PIE begins with the effective date of the return to the Service Area.

At Other Times for Employees and Retirees

Group Open Enrollment Period. You and your eligible Family Members may also enroll during a group Open Enrollment Period established by the University.

90-Day Waiting Period. 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 unless one of the "Special Circumstances" described below applies.

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 unless one of the "Special Circumstances" described below applies.

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.

Newly Eligible Child. If you have one or more children enrolled in the Plan, you may add a newly eligible Child at any time. See "Effective Date".

Special Circumstances. You may enroll before the end of the 90-day waiting period or without waiting for the University's next Open Enrollment Period if you are otherwise eligible under any one of the circumstances set forth below:

1) You have met all of the following requirements:

    a) You were covered under another health plan as an individual or dependent, including coverage under COBRA or Cal-COBRA (or similar program in another state), the Children's Health Insurance Program or "CHIP" (called the Healthy Families Program in California) or Medicaid (called Medi-Cal in California).

    b) You stated at the time you became eligible for coverage under WHA that you were declining coverage under WHA or deenrolling because you were covered under another health plan as stated above.

    c) Your coverage under the other health plan wherein you or your Eligible Family Members were covered as an individual or dependent ended because you lost eligibility under the other plan or employer contributions toward coverage under the other plan terminated, your coverage under a COBRA or

Cal-COBRA continuation was exhausted or you lost coverage under CHIP or Medicaid because you were no longer eligible for those programs.

d) You properly file an application with the University during the PIE which starts on the day after the other coverage ends. **Note that if you lose coverage under CHIP or Medicaid, your PIE is 60 days.**

2) You or your eligible Family Members are not currently enrolled and you or your eligible Family Members become eligible for premium assistance under the Medi-Cal Health Insurance Premium Payment (HIPP) Program or a Medicaid or CHIP premium assistance program in another state. Your PIE is 60 days from the date you are determined eligible for premium assistance. If the last day of the PIE falls on a weekend or holiday, the PIE is extended to the following business day. Electronic transactions must be completed by the deadline on the last day of the enrollment period.

3) A court has ordered coverage be provided for a spouse, domestic partner or dependent child under your UC-sponsored medical plan and an application is filed within the PIE which begins the date the court order is issued. (Family Member(s) must also meet UC eligibility requirements.)

4) You have a change in family status through marriage or domestic partnership, or the birth, adoption or placement for adoption of a child:

   a) If you are enrolling following marriage or establishment of a domestic partnership, you and your new spouse or domestic partner must enroll during the PIE. Your new spouse or domestic partner's eligible children may also enroll at that time. Coverage will be effective as of the date of marriage or domestic partnership provided you enroll during the PIE.

   b) If you are enrolling following the birth, adoption or placement for adoption of a child, your spouse or domestic partner, who is eligible but not enrolled, may also enroll at that time. Application must be made during the PIE; coverage will be effective as of the date of birth, adoption or placement for adoption provided you enroll during the PIE.

5) You meet or exceed a lifetime limit on all benefits under another health plan. Application must be made within 31 days of the date a claim or a portion of a claim is denied due to your meeting or exceeding the lifetime limit on all benefits under the other plan. Coverage will be effective on the first day of the month following the date you file the enrollment application.

If you are an Employee or a Retiree and there is a lifetime maximum for all benefits under this plan, and you or a Family Member reaches that maximum, you and your eligible Family Members may be eligible to enroll in another UC-sponsored medical plan. Contact the person who handles benefits at your location (or the UC Customer Service Center if you are a Retiree).

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). Retirement alone does not grant a PIE to enroll or change your medical plan.

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:

  a) The date the Child becomes eligible, or

  b) A maximum of 60 days prior to the date your Child's enrollment form is received by your local Benefits or Payroll Office.

Change in Coverage

In order to make any of the changes described above, contact the person who handles benefits at your location (or the UC Customer Service Center if you are a Retiree).

Effect of Medicare on Enrollment

As an Employee, if 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 employment.

As a Retiree, if you and/or your covered Family Member becomes eligible for premium-free Medicare Part A, then you and/or your covered Family Member must enroll, and remain, in Medicare Part B or you will permanently lose your UC-sponsored medical coverage.

You should contact your Social Security office three months before you and your Family Member's 65th birthday to inquire about your eligibility and how to enroll in Part A and Part B of Medicare. If you qualify for disability income benefits from Social Security, contact your Social Security office for information about when you will be eligible for Medicare enrollment. **Once Medicare coverage is established, you and eligible Family Members are no longer eligible to participate in this plan. You should contact UC Customer Service and transfer to another UC medical plan for which you are eligible.**

Medicare Secondary Payer (MSP) Law

The Medicare Secondary Payer (MSP) Law affects the order in which claims are paid by Medicare and an employer group health plan. Employees or their spouses, age 65 or over, and UC Retirees re-hired into positions making them eligible for UC-sponsored medical coverage, including CORE and mid-level benefits, are subject to MSP. For those eligible for a group health plan due to employment, MSP indicates that Medicare becomes the secondary payer and the employer plan becomes the primary payer. You and your spouse should carefully consider the impact on your health benefits and Premiums at age 65 or should you decide to return to work after you retire. Continued employment past age 65 may delay enrollment into Part B, however, once enrolled, Part B must be continuous.

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.

Deenrollment 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 hospitalized or undergoing treatment of a medical condition covered by WHA, benefits will cease to be provided and you may have to pay for the cost of those services yourself. You may be entitled to continued benefits under terms which are specified elsewhere in this document. (If you apply for an individual HIPAA or conversion plan, the benefits may not be the same as you had under WHA.)
- 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 sixty (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 deenrollment procedures, contact the person who handles benefits at your location (or the UC Customer Service Center if you are a Retiree).

Deenrollment Due to Fraud or Intentional Misrepresentation

Coverage for you and/or your Family Members may be suspended for up to 12 months if you or a Family Member commit fraud or make an intentional misrepresentation of material fact relating to Plan coverage. Individuals who are enrolled, but who are not eligible Family Members will be permanently deenrolled.

Leave of Absence, Layoff, Change in Employment Status or Retirement

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

Renewal Provisions

Annual renewal is automatic provided that your employer seeks to renew coverage under the same Group Service 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 Group Service Agreement

Your employer's group coverage can be terminated for any reason set forth in the Group Service Agreement. Also, your employer may terminate coverage with a written notice of cancellation to WHA. Coverage for all enrolled Members of the group, including any COBRA and Cal-COBRA members under the group, will end if the Group Service Agreement is terminated for any reason. Benefits cease on the date the Group Service Agreement terminates.

Effective Date of Termination of Coverage for Group Members

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 Service Agreement between the University and WHA is terminated.

Subscribers may cancel medical plan coverage or delete a Family Member from WHA 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.**

Individual Continuation of Benefits

If you lose your coverage through the University, you may be eligible to continue your benefits through COBRA, Cal-COBRA, HIPAA or a Conversion Option. Each of these is described in detail below.

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher Premium, or you could be denied coverage entirely.

Optional Continuation of Group Coverage (COBRA and Cal-COBRA)

As a participant in this plan you may be entitled to continue health care coverage for yourself, spouse or family members if there is a loss of coverage under WHA as a result of a qualifying event under the terms of the federal COBRA continuation requirements under the Public Health Service Act, as amended, and, if that continued coverage ends, you may be eligible for further continuation under California law. You or your family members will have to pay for such coverage. You may direct questions about these provisions to CONEXIS, UC's COBRA administrator or visit the website http://atyourservice.ucop.edu/employees/health_welfare/cobra.html.

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 provides 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 as 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" on the following pages.)

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 two (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 federal 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, fewer than twenty (20) employees) are exempt from COBRA, as are government health plans and church plans. Individuals who move out of the Service Area are not eligible for COBRA continuation coverage under WHA.

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:

1) 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 the following Qualifying Events:

   a) Your death; or

   b) 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

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

   d) You become entitled to Medicare benefits; or

   e) A dependent enrolled in your group benefit plan loses dependent status.

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

   a) Your death; or

   b) 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

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

   d) You become entitled to Medicare benefits; or

   e) 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 (fewer 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.

Individuals who move out of the Service Area are not eligible for Cal-COBRA continuation coverage under WHA.

Multiple Qualifying Events. The total period of continuation coverage under Cal-COBRA cannot exceed thirty-six (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 sixty (60) days after the second Qualifying Event (i.e., your death). However, your spouse may not receive, in total, more than thirty-six (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.

COBRA and Cal-COBRA Election, Premium, Termination, Normal Period and Premature Termination.

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 form to the following address, unless directed otherwise on the form:

Attn: COBRA Enrollment Department
Western Health Advantage
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833-9754

The form 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 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 return the form within the sixty (60) days time limit will disqualify you from participating in Cal-COBRA continuation coverage.**

COBRA and Cal-COBRA Premium Payments. 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 forty-five (45) days time limit will disqualify you from participating in Cal-COBRA or COBRA continuation coverage, even if you have previously made a timely election.**

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 one hundred two percent (102%) of the applicable group coverage rate. Under Cal-COBRA, the rate can be up to one hundred ten percent (110%) of the applicable group coverage rate. Finally, you may be required to pay up to one hundred fifty percent (150%) of the applicable group coverage rate if you are receiving continuation coverage past the eighteen (18) months federal COBRA period due to disability.

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 of COBRA or Cal-COBRA" 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 of COBRA or Cal-COBRA" 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.

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 as 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.

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 those whose loss is due to 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 provide certificates of coverage for Subscribers and dependents automatically.

If Subscribers or dependents have questions concerning HIPAA, they may contact Office of Civil Rights at (866) 627-7748 or at the following Internet address: www.hhs.gov/ocr/hipaa. To the extent that the provisions of the Group Service Agreement and EOC/DF do not comply with any provision of the HIPAA of 1996, they are hereby amended to comply.

Conversion Option

An employee or Member whose coverage under the Group Service Agreement has been terminated by the employer may be entitled to convert to a non-group conversion plan without evidence of insurability. It is the duty of the employer to notify a Subscriber of the availability, terms and conditions of the conversion coverage within fifteen (15) days of termination of a Subscriber's group coverage. A conversion contract shall not be required to be made available in the following circumstances:

1) The Group Service Agreement or an employer's participation terminated, and the Group Service Agreement is replaced by similar coverage under another group contract within fifteen (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 from the plan by the health care service 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.

Note: Conversion benefits are not available to any individual who does not live or work within the WHA Service Area.

Termination of Benefits, Fraud and Exception to Cancellation

Termination

Once you are enrolled in WHA, your coverage cannot be canceled because of health conditions. A Member may be terminated for the reasons specified in this EOC/DF.

If your WHA coverage is terminated for any of the reasons listed below, the Subscriber, Member or the employer group will be notified in writing of the reason for cancellation. Since you will remain a WHA Member until your termination date, any Medically Necessary services will continue to be provided in accordance with this EOC/DF. Your rights to benefits end on your coverage termination date except as described in the section titled "Exception to Cancellation of Group Benefits".

If you believe your membership was terminated improperly by WHA, you may submit a Grievance to WHA. See "Member Satisfaction Procedure", "Appeal and Grievance Procedure" in this EOC/DF. After participating in the WHA Grievance system for thirty (30) days or after receiving a resolution, whichever comes first, you may request a review of the termination by the California Department of Managed Health Care.

Reasons for Termination of a Member

1) You fail to pay the required Copayments or Deductibles to any Participating Provider or pharmacy benefit manager for services rendered after being properly notified and billed.

Members who are unwilling to make payment arrangements within forty-five (45) days of the date payment is due, or fail to comply with such arrangements when made, will be mailed a notice of cancellation. Termination will be effective fifteen (15) days after the date the notice was mailed, as stated on the notice of cancellation.

2) You commit fraud, intentionally provide incorrect or misleading facts or information that are material, or intentionally omit material facts or information that pertain to your and/or your family's eligibility or receipt of health care services. Termination may be effective as early as the date of the fraud or material misrepresentation or omission or, if the intentional misrepresentation or omission pertains to loss of eligibility, on the date that eligibility ended.

3) You seek and/or obtain medications under false pretenses to support a drug dependency or for the illegal sale of the medications. Termination shall be effective as early as the date of the fraud or material misrepresentation or omission.

4) You threaten the safety of Plan employees or providers, Members, or other patients; or your repeated behavior has substantially impaired the Plan's ability to furnish or arrange services for you or other Members, or a provider's ability to provide services to other patients. Termination will be effective fifteen (15) days after the date the notice was mailed, as stated on the notice of cancellation.

5) If a Subscriber or dependent fails to inform WHA that he or she no longer works or maintains a Primary Residence within the Service Area, coverage will be terminated for the individual, and if the Subscriber doesn't live or work in the Service Area, for any enrolled Family Members as well, effective midnight of the last day of the month following the conclusion of a 15-day notice period. 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. In this case, the Subscriber must maintain a Primary Residence within the Service Area, and 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, university or vocational school outside the Service Area as long as the Subscriber either works or maintains a Primary Residence within the Service Area (see "Eligible Dependents ("Family Members") and Age Limits").

6) You obtain or attempt to obtain Covered Services by means of fraud or intentional material misrepresentations or omissions; you permit any other person to use a Member's identification card to obtain services under this Health Plan or otherwise misuse your identification card; or you engage in any fraudulent conduct (see "Termination of Coverage", "Deenrollment Due to Fraud or Intentional Misrepresentation" above and "Fraud or Material Misrepresentation or Omission" below). In any of these cases, WHA may terminate coverage as early as the date of the fraud or material misrepresentation or omission.

7) The employer fails to pay Premiums due or the Subscriber fails to make any required contributions toward the cost of coverage. Termination will be effective on the last day of the month following a 30-day notice period.

8) Any other loss of eligibility under the terms of this EOC/DF. Termination will be effective following the conclusion of a 15-day notice period.

Please note that you may terminate coverage by giving written notice that you wish to disenroll. If you are the Subscriber, you are responsible for notifying any Family Members that coverage has been canceled.

Retroactive Termination of a Member

Note: WHA may terminate an individual's coverage only if allowed (or not disallowed) by federal and state laws and regulations.

Coverage may not be terminated retroactively by WHA unless:

- The Member committed fraud or intentionally misrepresented or omitted a material fact. Examples of material facts include, but may not be limited to:

  a) Moving out of the WHA Service Area (see "Becoming and Remaining a Member of WHA", "Service Area Requirement"; termination will be effective as early as the date that the Member was no longer eligible due to not meeting the WHA Service Area requirement);

  b) Becoming divorced from a Subscriber or ceasing to meet the requirements for domestic partnership with a Subscriber (termination will be effective as early as the date the divorce was effective or the domestic partnership ended);

  c) Ceasing to be a full-time student when outside the Service Area (see "Becoming and Remaining a Member of WHA", "Eligible Dependents ("Family Members") and Age Limits"; termination will be effective as early as the date that the Member was no longer eligible due to not meeting the WHA Service Area requirement);

  d) Ceasing to be covered by a qualified medical support order (QMSO) requiring a Subscriber or spouse of a Subscriber to cover you outside the Service Area (see "Becoming and Remaining a Member of WHA", "Eligible Dependents ("Family Members") and Age Limits"; termination will be effective as early as the date that

the Member was no longer eligible due to the QMSO expiring).

- The Member is no longer employed by a covered employer group (termination will be effective on the date employment ended).

Fraud or Material Misrepresentation or Omission

Coverage for a Subscriber or covered dependents may be terminated for fraud or material misrepresentation or omission, including but not limited to fraud or material misrepresentation or omission in providing or failing to provide material information to WHA, the use of the services of the Plan, or for knowingly permitting such fraud or material misrepresentation or omission by another. Such termination shall be effective upon the mailing of written notice by the Plan to the Subscriber and employer or may be retroactive to the date of the fraud or material misrepresentation or omission, if appropriate. Termination of coverage of a dependent for fraud shall not cancel the enrollment of other Family Members. Termination of coverage for a Subscriber shall automatically cancel the enrollment of all covered dependents. **Note:** WHA may terminate an individual's coverage only if allowed (or not disallowed) by federal and state laws and regulations.

Exception to Cancellation of Group Benefits

WHA does not cover any services or supplies provided after termination of the Group Service 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 as follows:

1) The Member is a registered bed patient in a hospital at the date of termination. The Member will continue to receive all benefits of coverage for the condition confining the Member to the hospital, subject to the payment fees and applicable Copayments and Deductibles, until those benefits expire or the Member is discharged from the hospital, whichever occurs first.

2) The Member is receiving inpatient obstetrical care at the date of termination and there has been no default in payment fees. Inpatient obstetrical care will continue only through discharge.

3) The Member is Totally Disabled by a condition for which the Member is receiving covered benefits. WHA will continue to maintain full coverage during the disabling condition, subject to the payment fees and applicable Copayments and Deductibles. Coverage will end (1) at the close of the twelfth (12th) month following termination, (2) when it is determined the Member is no longer disabled or (3) when the Member is covered under a replacement agreement or policy without limitations as to the disabling condition, whichever occurs first.

4) The Member has been notified that his/her coverage is being terminated retroactively for fraud or material misrepresentation or omission and has appealed the termination decision. Coverage for an ongoing course of treatment that was approved prior to the date of the termination will remain in effect from the date of the Appeal through resolution, subject to payment fees and applicable Copayments and Deductibles.

Refunds

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 thirty (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 for knowingly permitting such fraud or deception by another.

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 insurance contracts. 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.

This section describes how WHA is administered and what your rights are.

Sponsorship and Administration of the Plan

The University of California is the Plan sponsor and plan administrator for the Plan provisions described in this booklet. If you have a question about eligibility or enrollment, you may direct it to:

University of California
Human Resources
300 Lakeside Drive
Oakland, CA 94612
(800) 888-8267

Retirees and Survivors may also direct questions to the UC Customer Service Center at the above phone number.

Claims and Appeals for benefits under the Plan are processed by Western Health Advantage. If you have a question about benefits under WHA or about a specific claim, please contact WHA at the following address and phone number:

Western Health Advantage
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833
(916) 563-2252

Prescription claims under the Plan are processed by Medco Health. You can order claim forms online at medcohealth.com or by calling Medco Health Member Services at (800) 903-8664.

Group Service Agreement Number

The Group Service Agreement Number for this Plan is: 001021.

Type of Plan

WHA 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 portion of the Premiums that the 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 file an appeal regarding denied claims of benefits or services, refer to the "Member Satisfaction

Procedure" section found later in this document. Any appeals regarding coverage denials that relate to eligibility requirements are subject to the UC Group Insurance Regulations. To obtain a copy of the Eligibility Claims Appeal Process, please contact the person who handles benefits at your location (or the UC Customer Service Center if you are a Retiree).

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

Payment Fees

Your employer is responsible for payment of monthly Premiums for WHA coverage. You will be notified by your employer if you are required to pay a portion of these Charges. Health services are covered only for Members whose payment fees have been received by WHA and coverage extends only through the period for which such payment is received. (For COBRA and Cal-COBRA Members, see the information on the previous pages.)

Other Charges

Copayments

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

The Charges you pay for percentage Copayments are based on WHA's contracted rates with our Participating Providers and/or Medical Groups.

Some offices may advise you that a fee will be charged for missed appointments unless you give advance notice or missed the appointment because of an emergency situation.

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.

If you need to submit a claim, contact Member Services at one of the numbers listed below to find out where and how to submit it.

Out-of-Pocket Maximum Liability

The annual out-of-pocket maximum liability (OOP) for Members under this Plan is described in your Copayment Summary.

The Copayments you pay during the calendar year (including mental and behavioral health) will be applied to the OOP, except as described below. When you pay a Copayment for Covered Services, ask for and keep the receipt. When the receipts add up to the amount of the annual OOP, submit your receipts to WHA. Please call our Member Services Department to find out where to submit your receipts. After your submit your receipts showing that you have met the OOP, WHA will provide you with a document that shows you do not have to pay any additional Copayments for Covered Services through the end of the calendar year.

Unless stated otherwise in your Copayment Summary, Copayments for the following Covered Services will not be applied to the OOP. You are required to continue to pay Copayments for these Covered Services after the OOP has been reached:

- Prescription Drugs, including oral and injectable medications.

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

Coordination of Benefits

Coordination of benefits ("COB") is a process used by WHA and other health plans, employer benefit plans, union welfare plans, HMOs, insurance companies, government programs and other types of payors ("Insurers") to make sure that duplicate payments are not made for the same claims when more than one Insurer covers a Member. This section summarizes the key rules by which WHA and other Insurers will determine the order of payment of claims while providing that the Member does not receive more than one hundred percent (100%) coverage from all Insurers combined.

All of the benefits provided under this EOC are subject to COB. You are required to cooperate and assist with WHA's coordination of benefits by telling all of your health care providers if you or your dependents have any other coverage. You are also required to give WHA your Social Security Number and/or Medicare identification number to facilitate coordination of benefits.

Definitions

"Primary Carrier" means the Insurer whose coverage is primary to other Insurers and should pay first, up to its limits. If any covered expenses remain after the Primary Carrier has paid, those would be paid by a "Secondary Carrier".

Rules When There is More Than One Commercial (Non-Medicare) Insurer

These rules should be applied in the order in which they are listed in determining which Insurer is the Primary Carrier and which is a Secondary Carrier:

1) Insurer Without COB Provision is Primary Carrier

The following rules apply when there are two Insurers and both have a COB provision:

2) Insurer covering Patient as an active or retired Employee is the Primary Carrier

   When the Patient is the Employee with one Insurer and the dependent with another, the Insurer that covers the Patient as the Employee is the Primary Carrier.

3) When the Patient is a Dependent Child With Both Insurers, the Birthday Rule Applies

The Insurer of the Subscriber whose birthday occurs earliest in the calendar year is the Primary Carrier for the dependents covered under that Subscriber's group health plan. The Insurer of the Subscriber whose birthday occurs later in the calendar year is the Secondary Carrier for dependents covered under that Subscriber's group health plan.

4) How Primary Carrier for Divorced or Legally Separated Spouses is Determined

a) If spouses are legally separated or divorced and a court decree directs one parent to be financially responsible for the child's medical, dental, or other health care expenses, the Insurer of the parent who is financially responsible will be the Primary Carrier.

b) If there is no court decree regarding health care responsibility, the Insurer of the parent with custody is the Primary Carrier.

5) Unmarried Spouses With Legal Custody

When there has been a divorce and the court has not assigned financial responsibility for the child's medical, dental, or other health care expenses, and the parent with legal custody of the child has not remarried, the Insurer of the parent with legal custody of the child is the Primary Carrier for the child, and the Insurer of the parent who does not have legal custody is the Secondary Carrier.

6) Remarried Spouses

In the case of a divorced parent, when the court has not assigned financial responsibility for the child's medical, dental, or other health care expenses, and the parent has remarried, the Insurer who covers the child as the dependent of the parent with custody is the Primary Carrier, and the stepparent's Insurer is the Secondary Carrier. The Insurer of the parent without custody is tertiary. If the parent with custody does not have his or her own health coverage, the stepparent's Insurer is then the Primary Carrier and the Insurer of the parent without custody becomes the Secondary Carrier.

7) When the Court Orders Joint Custody

When the court has awarded joint custody of dependent children to divorced or legally separated parents, WHA applies the birthday rule.

8) Retired and Laid-off Employees

When a retired or laid-off employee has more than one Insurer, the Insurer who provides coverage to the Member as an active employee is primary; the Insurer providing coverage as a retirement benefit is secondary.

9) When rules one through eight do not establish an order of benefit determination the Insurer who has covered the patient the longest is the Primary Carrier.

Rules for Coordination with Medicare Coverage

Note: Medicare coordination of benefits rules are complex. Following is a general summary of the Medicare rules. If there is any conflict between this summary and the federal statutes and/or regulations, the federal statutes/regulations control.

WHA is the Primary Carrier for Members meeting the following criteria:

1) Working Aged

A Medicare working aged individual is a person who meets either a, b, or c:

a) An age 65 or over working individual who:

1) Works for an employer that employs 20 or more employees, and

2) Is covered under that employer's health plan and entitled to Part A & B

b) Age 65 or over and a spouse of a worker employed by an employer of 20 or more employees who is covered under an employer's health plan and entitled to Part A & B, or

c) A self employed worker or spouse age 65+ who is:

1) Covered by the employer's health plan through association with a firm which employs 20 or more employees, and

2) Entitled to Part A & B.

2) Retiree

If Member is retired, over age 65, and part of an Employer Group Health Plan (EGHP), Medicare is primary regardless of group size. If Member is age 65 or over and covered by Medicare and COBRA, Medicare is always primary to the COBRA plan.

3) End Stage Renal Disease/Permanent Kidney Failure

A WHA commercial plan is primary to Medicare during a 30-month coordination period for beneficiaries who have Medicare because of permanent kidney failure. This rule applies to both those with permanent kidney failure who have their own coverage under WHA and to those covered under WHA as dependents. Additionally, this rule applies without regard to the number of employees or to the enrollee's employment status (i.e., Member can be on COBRA). The period for which WHA would be the primary payer begins with the earlier of:

a) The first month of the enrollee's entitlement to Medicare Part A on the basis of permanent kidney failure, or

b) The first month in which the enrollee would have been entitled to Medicare Part A if he or she had filed an application for Medicare on the basis of permanent kidney failure.

4) Disability

a) A WHA commercial plan is primary for Members under the age of 65 who have Medicare because of a disability and who are covered under a Large Group Health Plan (LGHP) through their current employment or through the current employment of any family member. An LGHP is an employer which employs at least 100 employees.

b) Note: This does not apply to disabled retirees. Medicare is always primary for retirees with a disability. Medicare is also primary to disabled Members who are on COBRA.

Other COB Rules

1) Duplicate Coverage

a) If a Member is covered by more than one WHA commercial group plan and is enrolled with the same PCP for both plans, all Copayments are waived.

b) WHA's Copayments are also waived when WHA is the Secondary Carrier, provided that the payment as the Secondary Carrier does not exceed the amount that WHA would have paid as the Primary Carrier. In the event that the payment would exceed WHA's liability as Primary Carrier if the Copayment is waived, the Member may be charged the WHA Copayment.

c) In addition, when a Member is covered by more than one plan and a benefit stipulates a maximum number of visits, the Member is entitled to the number of visits in the plan with the greater benefit. Example: If one plan covers 20 visits and the other 50 visits, the Member is limited to a total of 50 visits.

2) Pharmacy Benefits

With regards to pharmacy benefits, when WHA is the Secondary Carrier, or Member has dual WHA coverage, the Member must pay their Copayments at the time of service and submit their receipts to WHA for reimbursement. Reimbursement will be made to the Member as long as the Prescription is covered under their pharmacy benefit plan and Member obtained the Prescription from a Participating Pharmacy. The maximum reimbursement to a Member can not exceed what WHA would have paid if WHA were the Primary Carrier.

3) Disagreements With Other Insurers

For various reasons, WHA may encounter Insurers, administrators, and others who would ordinarily be the Primary Carrier but refuse to pay. When disagreements arise with Insurers, WHA abides by the rules employed by the other Insurer. WHA is obligated to provide all Covered Services regardless of WHA's ability to coordinate benefits.

Third Party Responsibility – Subrogation

In the event a Member suffers injury, illness or death due to the act or omission of a third party (including but not limited to vehicle accidents, slip and falls, dog bites, work injuries, etc.) and complications incident thereto, WHA will furnish Covered Services. In the event any Recovery is obtained by the Member or his or her Representative due to such injury, illness or death, the Member and his or her Representative must reimburse WHA for the value of Covered Services as set forth below. By executing an enrollment application or otherwise enrolling in this Plan, each Member grants WHA or its Medical Group/IPA, as appropriate, a lien on any such Recovery and agrees to protect the interests of WHA when there is any possibility that a Recovery may be received. Each Member also specifically agrees as follows:

1) Immediately following the initiation of any injury, illness or death claim, the Member or his or her Representative shall provide the following information to WHA's Recovery Agent in writing: the name and address of the third party; the name of any involved attorneys; a description of any potentially applicable insurance policies; the name and telephone number of any adjusters; the circumstances which caused the injury, illness or death; and copies of any pertinent reports or related documents;

2) Each Member or Representative shall execute and deliver to WHA or its Recovery Agent any and all lien authorizations, assignments, releases or other documents requested which may be needed to fully and completely protect the legal rights of WHA;

3) Immediately upon receiving any Recovery, the Member or Representative shall notify WHA's Recovery Agent and shall reimburse WHA for the value of the services and benefits provided, as set forth below. Any such Recovery by or on behalf of the Member and/or 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 the Member and/or Representative receives any Recovery which does not specifically include an award for medical costs, WHA will nevertheless have a lien against such Recovery; and

4) Any Recovery received by the Member or Representative shall first be applied to reimburse WHA for Covered Services provided and/or paid, regardless of whether the total amount of Recovery is less than the actual losses and damages incurred by the Member and/or Representative.

Where used within this provision, "WHA" means Western Health Advantage, Participating Hospitals or Physicians providing Covered Services and/or their designees.

"Recovery" means any compensation received from a judgment, decision, award, insurance payment or settlement 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, including uninsured and underinsured motorist claims.

"Recovery Agent" means the law firm of Tennant & Ingram at the following contact information:

WHA TPL
c/o Tennant & Ingram
2101 W Street
Sacramento, CA 95818
(916) 244-3400
(916) 244-3440 fax

WHA reserves the right to change the Recovery Agent upon written notification to employer groups, Subscribers or Members via a Plan newsletter, direct letter, e-mail or any other written notification.

"Representative" means any person pursuing a Recovery due to the injury, illness or death of a Member, including but not limited to the Member's estate, representative, family member, appointee, heir or legal guardian.

The following section is not applicable to workers' compensation liens, may not apply to certain ERISA plans, hospital liens, and Medicare plans and certain other plans, and may be modified by written agreement.*

The amount WHA is entitled to recover for capitated and/or noncapitated Covered Services pursuant to its reimbursement rights described in this EOC/DF is determined in accordance with California Civil Code Section 3040. Normally, this amount will not exceed one third (1/3) of the Recovery if the Member or Representative engages and pays an attorney or one half (1/2) of the Recovery if no attorney is engaged and paid. WHA's lien is subject to reduction if any final judgment includes a special finding by a judge, jury or arbitrator that the Member was partially at fault for the incident. In that case, the lien will be reduced commensurate with the Member's percentage of fault as determined by the final judgment. This reduction will be calculated using the total value of the lien, and prior to any other reductions.

** Reimbursement related to worker's compensation benefits, ERISA plans, hospital liens, Medicare and other programs not covered by Civil Code Section 3040 will be determined in accordance with the provisions of this EOC/DF and applicable law.*

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.

Member Satisfaction Procedure

WHA strives to provide exceptional health care services to you. If you have a concern about your medical care, you should discuss it with your PCP. If you need help answering your questions, clarifying procedures or investigating Complaints, call Member Services between 8 a.m. and 5 p.m. Monday through Friday, at one of the numbers listed below.

If you prefer, you can visit or write to:

Attn: Appeals and Grievance Coordinator
Member Services Department
Western Health Advantage
2349 Gateway Oaks Drive, 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.

Information and Assistance in Other Languages

WHA is committed to providing language assistance with the Appeal and Grievance Procedure, Expedited Appeal Review and Independent Medical Review to Members whose primary language is not English. To get help in your language, please call Member Services at one of the phone numbers listed below.

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, or wish to appeal a retroactive termination (other than for non-payment of required Premiums or employee contributions to the cost of coverage), 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:

Attn: WHA Member Services, Appeals Department
Western Health Advantage
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833

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, Appeals Department within one hundred eighty (180) days of the incident or action that caused your dissatisfaction. If you are unable to meet this period, please contact Member Services on how to proceed.

If you are appealing a denial of services included within an already-approved ongoing course of treatment, coverage for the approved services will be continued while the Appeal is being decided. If you are appealing a retroactive termination of coverage (other than for non-payment) and your coverage has already been terminated, you will be provisionally reinstated while your Appeal is being decided; all Premiums must continue to be paid timely for coverage to continue. At the conclusion of the Appeal, including any Appeal to the California Department of Managed Health Care (see below), if the Appeal is decided in your favor, you will be reinstated retroactively to the date your coverage was initially terminated. All Premiums must be paid timely.

WHA sends an acknowledgment letter to the Member within five (5) calendar days of receipt of the Appeal or Grievance. A determination is rendered within thirty (30) calendar days of receipt of the Member's Appeal. WHA will notify the Member of the determination, in writing, within three (3) working days of the decision being rendered.

A Grievance Form and a description of the Grievance procedures are available at every Medical Group and Plan facility and on WHA's web site. In addition, a Grievance Form will be promptly sent to you if you request one by calling Member Services. If you would like assistance in filing a Grievance or an Appeal, please call Member Services and a representative will assist you in completing the Grievance 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 Grievances within thirty (30) days of receipt. For Appeals of denials of coverage or benefits, you will be given the opportunity to review the contents of the file and to submit testimony to be considered. Written notification of the disposition of the Grievance or 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 Appeal and Grievance procedure.

The California Department of Managed Health Care (DMHC) 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 one of the numbers listed below 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 thirty (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 an 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 ((888) 466-2219), and a TDD line, (877) 688-9891, for the hearing and speech impaired. The

department's Internet Web site, 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 Behavioral Health or Chemical Dependency Detoxification Benefits

For any Complaints regarding behavioral health and chemical dependency services, please contact United Behavioral Health, your behavioral health health and chemical dependency carrier, at (888) 440-8225. If you believe that UBH is not providing these services at the same level as your medical benefits, including the same Copayments and Deductibles, please contact WHA at the phone numbers above under "Appeal and Grievance Procedure", or contact the DMHC as described above.

Expedited Appeal Review

An expedited Appeal is a request by the Member, by a practitioner on behalf of the Member or by a representative for the Member requesting reconsideration of a denial of services which requires that a review and determination be completed within seventy-two (72) hours, as the treatment requested may be addressing severe pain or an imminent and 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 request in person or by telephone from the Member, a practitioner on behalf of the Member or a representative of the Member. To request an expedited Appeal via telephone, please call Member Services at one of the numbers listed below.

The request is logged and all necessary information is collected in order to review and render a decision. You will be notified of your right to immediately contact the Department of Managed Health Care and that it is not necessary to participate in WHA's Grievance process prior to applying to the Department of Managed Health Care for review of an urgent Grievance.

If WHA determines that a delay of the requested review meets the criteria above, 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 seventy-two (72) hours after the review began. A letter documenting the decision, whether it is to overturn or to uphold the original denial, is sent to the practitioner, with a copy to the Member, within two (2) working days of the decision. The letter contains all clinical rationale used in making the decision.

Independent Medical Review (IMR)

Members may seek an Independent Medical Review (IMR) through the Department of Managed Health Care (DMHC) whenever covered health care services have been denied, modified or delayed by WHA, its contracting Medical Groups or its Participating Providers if the decision was based in whole or in 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. All Disputed Health Care Services are eligible for an IMR if the following requirements are met:

1) a) The Member's provider has recommended the health care services as Medically Necessary; or

   b) The Member has received an Urgent Care or Emergency Service that a Provider determined was Medically Necessary; or

   c) In the absence of a. and b. above, the Member has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the Member seeks an IMR.

2) The Disputed Health Care Service has been denied, modified or delayed based on WHA's decision that it is not Medically Necessary.

3) The Member has filed a Grievance with WHA and the decision has been upheld or remains unresolved past thirty (30) days. The DMHC (also called the "Department") may waive the requirement that the Member participate in the Plan's Grievance process in extraordinary or compelling cases.

There is no application or processing fee required.

When WHA receives notice from the Department that the Member's request for an IMR has been approved, WHA will submit the documents required by Health & Safety Code §1374.30(n) within three (3) days. The decision of the Independent Medical Review agency is binding on WHA.

To apply for an IMR, please call our Member Services Department between 8 a.m. and 5 p.m., Monday through Friday, at one of the numbers listed below to request the application form. Or if you prefer, you can come directly to our office or request the form in writing at:

Attn: Appeals and Grievance Coordinator
Member Services Department
Western Health Advantage
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833

Independent Medical Review of Investigational/Experimental Treatments

WHA excludes from coverage services, medication or procedures which are considered investigational and/or experimental 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 Service, 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 Seriously Debilitating Condition and it is determined by a Physician that the Member is likely to die within two (2) years or that the Member's health or ability to function could be seriously harmed by waiting the usual thirty (30) business days for review; if the Member's treating Physician certifies that the Member has a condition for which the standard therapies have not been effective or would not be medically appropriate; or if we do not cover a more beneficial standard therapy than the one proposed by the Member or his/her Physician, an expedited review may be requested. In that case, a decision will be rendered within seven (7) business days. The Appeal request may be verbal or written. You may apply to the Department of Managed Health Care (DMHC) for Independent Medical Review. The DMHC does not require that an enrollee participate in the Plan's Grievance system prior to seeking an IMR of a decision to deny coverage on the basis that the treatment or service is considered experimental/investigational.

The written request can be submitted to the Plan at:
Attn: WHA Member Services, Appeals Department
Western Health Advantage
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833

A WHA Member has the right to request an Independent Medical Review when coverage is denied as an Experimental or Investigational Procedure and the Member's Physician certifies that the Member has a terminal condition for which standard therapies are not or have not been effective in improving the Member's condition, or would not be medically appropriate for the Member, or that there is no more beneficial standard therapy covered by WHA than the therapy recommended, pursuant to 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 (2) 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 Seriously Debilitating Condition who meets the criteria above disagrees with the denial of a service, medication, device or procedure deemed to be experimental, he/she 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 of the date of the request.

You may apply to the Department of Managed Health Care (DMHC) for an Independent Medical Review (IMR) of the denial of a treatment or service that is experimental or investigational. The DMHC does not require that an enrollee participate in the Plan's Grievance system prior to seeking an IMR of a decision to deny coverage on the basis that the treatment or service is considered experimental/investigational. There is no application or processing fee required. When WHA receives notice from the DMHC regarding the Member's application for an IMR, WHA will submit all of the enrollee's medical records from the Plan or its contracting providers within three (3) business days. The decision of the IMR review agency is binding on WHA.

If the Member is not in a Life-Threatening or Seriously Debilitating Condition or if his/her health or ability to function will not be seriously harmed by waiting, the decision will be rendered within thirty (30) business days. The independent expert may request that the deadline be extended by up to three (3) days due to a delay in receiving all of the necessary documentation from WHA, the Member and/or the Physician.

If the enrollee's in-network or out-of-network Physician determines that the proposed experimental / investigational therapy would be significantly less effective if not promptly initiated, the analyses and recommendations of the experts on the IMR panel shall be rendered within seven (7) days of the request for expedited review.

Binding Arbitration

Disputes between you and WHA are typically handled and resolved through WHA's Grievance, Appeal and Independent Medical Review processes described above. However, in the event that a dispute is not resolved in those processes, WHA uses binding arbitration as the final method for resolving all such disputes.

As a condition of your membership in WHA, you agree that any and all disputes between yourself (including any heirs or assigns) and Western Health Advantage, including claims of medical malpractice (that is as to whether any Medical Services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for Small Claims Court cases and claims subject to ERISA, shall be determined by binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. You and WHA, including any heirs or assigns to this agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

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.

If the parties fail to reach an agreement on arbitrator(s) within thirty (30) days of the filing of the arbitration with the American Arbitration Association, then either party may apply to a court of competent jurisdiction for appointment of the arbitrator(s) to hear and decide the matter.

A Member may initiate arbitration by submitting a demand for arbitration to WHA at the address that follows.

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

Attn: CFO
Western Health Advantage
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833

The arbitration procedure is governed by the American Arbitration Association commercial rules. Copies of these rules and other forms and information about arbitration are available through the American Arbitration Association at adr.org or (800) 778-7879.

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this EOC/DF, 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 the Member's share of the fees and expenses associated with 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 a request for hardship should be submitted to 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 to mandatory binding arbitration any disputes about certain "adverse benefit determinations" made by WHA. 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

Capitalized terms used in this EOC/DF that aren't listed here are defined in the body of the EOC/DF.

Appeal means 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.

Brand Name Medication is a Prescription Medication manufactured, marketed, and sold under a given name.

Charges means the Participating Provider's 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.

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

Copayment means an additional fee charged to a Member which is approved by the California Department of Managed Health Care, provided for in the Group Service Agreement and disclosed in this EOC/DF or in the Member's Copayment Summary. Percentage Copayments are based on WHA's contracted rates for service.

Coverage Decision means the approval or denial of health care service by the Plan or by one of its Contracted 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, described in the "Principal Benefits and Covered Services" section and not excluded or limited by the "Principal Exclusions and Limitations" section of this EOC/DF.

Custodial 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.

Deductible means the amount of money a Member or family must pay for Covered Services before WHA will cover those services.

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 or by one of its contracting Medical Groups or Participating Providers, due in whole or in part 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, that is primarily and customarily used to serve a medical purpose and that 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, including a Mental Disorder or 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 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 and/or her unborn child; or
- 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 either standard medical practice by informed medical professionals in the United States at the time the services, tests, treatments, supplies, devices or drugs are rendered, or as safe and effective in treating or diagnosing the condition for which their use is proposed.

Generic Medication means a Prescription Medication that is medically equivalent to a Brand Name Medication in all facets: purity, safety, strength and effectiveness.

Grievance means 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 Participating Providers.

Group Service Agreement means the UC Health and Welfare Insured Plans – 2011 Standardized Contract 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 in writing by a Participating Physician to be terminally ill (i.e., the Member's medical prognosis is that the life expectancy is twelve months or less), emphasizing supportive services and dietary counseling under the direction of a Participating Physician in accordance with a written plan of care, including but not limited to services that are home-based.

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

Independent Medical Review means a review that the Member has the opportunity to seek whenever health care services have been denied, modified or delayed by the Plan or by one of its 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:

1) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.

2) Diseases or conditions with potentially fatal outcomes, when the goal of clinical intervention or treatment is survival.

Maintenance Medication means any covered Prescription Medication that is to be taken beyond 60 days. Examples include medications for high blood pressure, diabetes, arthritis, allergy 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 or **Contracted 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 "Principal Benefits and Covered Services" and which are performed, prescribed or directed by a Primary Care Physician or Specialist Physician.

Medically Necessary means that which WHA determines:

- Is appropriate and necessary for the diagnosis or treatment of the Member's medical condition, in accordance with professionally recognized standards of care;

- Is not mainly for the convenience of the Member or the 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 qualified dependent Family Member who is entitled to receive Covered Services.

Non-Preferred Medication (Tier 3) means a Generic or Brand Name Medication that is not listed on the WHA Preferred Drug List (PDL).

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 and affixed to the body externally to support or correct a defect or function of an injured or diseased body part, 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 or a Contracted Medical Group 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 by WHA's contract with the hospital.

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

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

Participating Provider means a Contracted Medical Group, 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 one of the numbers listed below.

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 "physician and surgeon" under California law.

Plan refers to the WHA plan of health care benefits described in this EOC/DF.

Preferred Brand Name Medication (Tier 2) means a Brand Name Medication that is listed on the WHA Preferred Drug List (PDL).

Preferred Drug List (PDL) is a listing of medications developed by WHA's Pharmacy and Therapeutics (P&T) Committee as drugs of choice in their respective classes of "Preferred Generic Medication" or "Preferred Brand Name Medication".

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

Preferred Generic Medication (Tier 1) means a Generic Medication that is listed on the WHA Preferred Drug List (PDL).

Premium means the payment fee to be paid by or on behalf of Members in order to be entitled to receive Covered Services.

Prescription is a written or oral order for a Prescription medication directly related to the treatment of an illness or injury and is issued by the attending Physician within the scope of his or her professional license.

Prescription Medication is a drug which has been approved by the FDA and which can, under federal or state law, be dispensed only pursuant to a Prescription.

Primary Care Physician or **PCP** means a Participating Physician who:

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

2) Acts as the coordinator of care, including such responsibilities as supervising continuity of care, record keeping and initiating referrals to Specialist Physicians for Members who select such a Primary Care Physician; and

3) Is designated as a Primary Care Physician by the Medical Group.

Primary Residence applies to each Subscriber and dependent individually, and means a residence in which the Subscriber or dependent presently, permanently and physically resides on a full-time basis, no fewer than eight (8) continuous months out of any 12-month period. **A residence in which a Subscriber or dependent resides only on a limited basis (such as only on weekends) does not qualify as a Primary Residence.**

Prior Authorization means written approval from the Medical Director before a service or supply is received. In most instances, the Medical Director delegates this function to a Medical Group.

Prosthetic Device means an artificial device externally affixed to the body to replace a missing part of the body or a device to restore a method of speaking incident to a laryngectomy. "Prosthetic Devices" does not include electronic voice producing machines.

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 health care 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 EOC/DF. For additional information regarding provider compensation issues, Members may request additional information from WHA, the provider or the provider's Medical Group or IPA.

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

Service Area means the geographic area in which WHA has been authorized by applicable regulatory agencies to provide routine Covered Services to Members. See the first page for a Service Area map and a list of zip codes within the Service Area.

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

Subscriber means the person whose employment or other status (except for family dependency) is the basis for eligibility, who meets all applicable eligibility requirements of the University and has enrolled in accordance with the "Eligibility, Enrollment and Termination" section of this EOC/DF.

Three-tier Copayment Plan means Preferred Generic Medications listed on the PDL are covered at the lowest tier Copayment level, Brand Name Medications listed on the PDL are provided at the second tier Copayment level, and drugs not listed on the PDL are covered at the third tier Copayment level. There are a small number of drugs, regardless of tier, that may require Prior Authorization to ensure appropriate use based on criteria set by the WHA P&T Committee. Please note that a drug's presence on the WHA PDL does not guarantee that the Member's Physician will prescribe the drug. Members may request a copy of the PDL by calling WHA Member Services or view the document on WHA's website at 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 twenty-four (24) hours, in order to prevent the serious deterioration of a Member's health due to an unforeseen illness or injury. Members must contact their Primary Care Physician, whenever possible, before obtaining Urgent Care.

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

WHA means Western Health Advantage.

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Medical Group 7, 8, 9, 11, 12, 13, 14, 15, 16, 20, 24, 28, 43, 47, 48, 51, 52, 53
Medical Necessity 23, 27, 29, 47
Medicare 8, 9, 11, 30, 36, 38, 43, 44–45, 46, 52
Network 11, 13, 16, 49
Obstetrics 11, 12, 14, 16, 40, 53
Occupational Therapy 21

Office Visit **20**
Orthotics **25, 27, 28, 52**
Out-of-Pocket Maximum (OOP) **22, 24, 43**
Pap Smear **21**
Physical Examination **20, 29**
Pregnancy **16, 24, 28**
Premium **33, 34, 35, 37, 39, 43, 53**
Prescription Medication **22–24, 51, 52, 53**
Primary Care Physician (PCP) **11, 12, 13, 14, 15, 19, 27, 47, 52, 53, 54**
Privacy **7–10, 18**
Private-Duty Nurse **21**
Prostate **21**
Prosthetics **25, 27, 28, 53**
Rehabilitative Services **20, 21, 29**
Relative **27, 30**
Service Area **1, 11, 14, 15, 22, 27, 30, 32, 38, 39, 54**
Skilled Nursing **12, 25, 27**
Smoking Cessation **28**
Specialist **11, 13–14, 16, 20, 52, 53, 54**
Speech Therapy **21**
Spouse **30, 32, 33, 35, 36, 37, 44**
Student **39**
Subrogation (see Third Party Responsibility)
Surrogacy **28**
Termination **11, 16, 30, 34–35, 35, 36, 37, 38–39, 41, 54**
Third Party Responsibility **29, 45–46**
Tier 1, Tier 2, Tier 3 Medications **22, 23, 52, 53, 54**
Totally Disabled **40, 54**
Transplants **24, 25, 27, 28, 29**
Urgent Care **12, 13, 14–15, 29, 48, 54**
Vision **14, 27**
Weight Loss **23, 28**
Well-Baby Care **20**
Wheel Chair (see Durable Medical Equipment)
Workers' Compensation **8, 11, 29, 46**
X-Ray **20, 21, 29, 51**

Appendix A*
Preventive Services Covered without Cost-Sharing

The following preventive services are covered without copayment or cost-sharing. Your plan may provide additional preventive services at no cost to you; consult your Copayment Summary for more information.

Service	Adults		Special Populations	
	Men	Women	Pregnant Women	Children
Abdominal Aortic Aneurysm, Screening[1]	x			
Alcohol Misuse Screening and Behavioral Counseling Interventions by PCP	x	x	x	
Anemia, Prevention - Counseling by PCP[2]				x
Anemia, Screening[3]			x	
Anemia, Screening - Hemoglobin/Hematocrit in Childhood[4]				x
Annual Well Visits for Children[5]				x
Annual Women's Well Visits[6]		x		
Aspirin for the Prevention of Cardiovascular Disease, Counseling by PCP (Aspirin is Over the Counter and Not Covered)[7]	x	x		
Asymptomatic Bacteriuria in Adults, Screening[8]			x	
Breast Cancer, Screening[9]		x		
Chemoprevention for Breast Cancer for High Risk Women, Discussion with PCP		x		
Breast and Ovarian Cancer Susceptibility, Genetic Risk Assessment and BRCA Mutation Testing[10]		x		
Breastfeeding, Counseling by PCP Regarding Behavioral Interventions[11]		x	x	
Cervical Cancer, Screening[12]		x		
Chlamydial Infection, Screening[13]		x	x	
Colorectal Cancer, Screening[14]	x	x		
Congenital Hypothyroidism, Screening[15]				x
Dental Caries in Preschool Children, Prevention[16]				x
Depression (Adults), Screening[17]	x	x		
Diet, Behavioral Counseling by PCP to Promote a Healthy Diet[18]	x	x		
Folic Acid Supplementation, Generic Prescription Folic Acid (Brand Name and Over the Counter are Not Covered)[19]			x	
Gonorrhea, Screening[20]		x	x	
Gonorrhea, Prophylactic Medication[21]				x
Hearing Loss in Newborns, Screening[15]				x
Hepatitis B Virus Infection, Screening[22]			x	
High Blood Pressure, Screening	x	x		
HIV, Screening[23]	x	x	x	x
Lead Screening up to Age 7				x
Lipid Disorders in Adults, Screening[24]	x	x		

Service	Adults		Special Populations	
	Men	Women	Pregnant Women	Children
Major Depressive Disorder in Children and Adolescents, Screening[25]				x
Obesity in Adults, Screening[26]	x	x		
Osteoporosis in Postmenopausal Women, Screening[27]		x		
Phenylketonuria, Screening[15]				x
Rh (D) Incompatibility, Screening[28]			x	
Sexually Transmitted Infections, Counseling by PCP or OB/GYN[29]	x	x		x
Sickle Cell Disease, Screening[15]				x
Syphilis Infection, Screening[30]	x	x	x	
TB Skin Test				x
Tobacco Use and Tobacco-Caused Disease, Counseling by PCP and Generic Prescription Medications (Brand Name and Over the Counter Medications Not Covered)[31]	x	x	x	
Type 2 Diabetes Mellitus in Adults, Screening[32]	x	x		
Visual Impairment in Children Younger than Age 5 Years, Screening[33]				x

Footnotes:

* This Appendix A includes the evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved (http://www.ahrq.gov/clinic/pocketgd09/gcp09s1.htm) and, with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources Services Administration. In order for an office visit to be considered "preventive," the service must have been provided or ordered by your PCP, or an OB/GYN who is a Participating Physician within your Medical Group or participating in Advantage Referral, and the primary purpose of the office visit must have been to obtain the preventive service. WHA and its Medical Groups may impose reasonable medical management techniques to determine the frequency, method, treatment or setting for a preventive service or item unless the particular guideline itself specifies otherwise. WHA does not cover any medications or supplements that are generally available over the counter, even if the Member has received a Prescription for the medications or supplements.

[1] One-time screening by ultrasonography in men aged 65 to 75 who have ever smoked.

[2] Counseling regarding routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia. Iron supplements are available over the counter and are not covered.

[3] Routine screening in asymptomatic pregnant women.

[4] Screening for anemia in children under age 18.

[5] Children under age 18.

[6] Women of all ages.

[7] When the potential harm of an increase in gastrointestinal hemorrhage is outweighed by a potential benefit of a reduction in myocardial infarctions (men aged 45-79 years) or in ischemic strokes (women aged 55-79 years).

[8] Pregnant women at 12-16 weeks gestation or at first prenatal visit, if later.

[9] Mammography every 1-2 years for women 40 and older.

[10] Referral for women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes for genetic counseling and evaluation for BRCA testing.

[11] Interventions during pregnancy and after birth to promote and support breastfeeding.

[12] Women aged 21-65 who have been sexually active and have a cervix.

[13] Sexually active women 24 and younger and other asymptomatic women at increased risk for infection. Asymptomatic pregnant women 24 and younger and others at increased risk.

[14] Adults aged 50-75 using fecal occult blood testing, sigmoidoscopy, or colonoscopy. Procedures to treat any abnormalities will require a copayment, even if performed at the same time as the screening.

[15] Newborns.

[16] Prescription of oral fluoride supplementation at currently recommended doses to preschool children older than 6 months whose primary water source is deficient in fluoride.

[17] In clinical practices with systems to assure accurate diagnoses, effective treatment, and follow-up.

[18] Adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease.

[19] Recommendation that women pregnant or planning on pregnancy have folic acid supplement.

[20] Sexually active women, including pregnant women 25 and younger, or at increased risk for infection.

[21] Prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum.

[22] Pregnant women at first prenatal visit.

[23] All adolescents and adults at increased risk for HIV infection and all pregnant women.

[24] Men aged 20-35 and women over age 20 who are at increased risk for coronary heart disease; all men aged 35 and older.

[25] Adolescents (age 12-18) when systems are in place to ensure accurate diagnosis, psychotherapy, and follow-up.

[26] Discussion/counseling about intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.

[27] Women 65 and older and women 60 and older at increased risk for osteoporotic fractures.

[28] Blood typing and antibody testing at first pregnancy-related visit. Repeated antibody testing for unsensitized Rh (D)-negative women at 24-28 weeks gestation unless biological father is known to be Rh (D) negative.

[29] All sexually active adolescents and adults at increased risk for sexually transmitted infections.

[30] Persons at increased risk and all pregnant women.

[31] Discussion/counseling about tobacco cessation interventions for those who use tobacco. Augmented pregnancy-tailored counseling to pregnant women who smoke. Generic prescription medications are covered.

[32] Asymptomatic adults with sustained blood pressure greater than 135/80 mg Hg.

[33] To detect amblyopia, strabismus, and defects in visual acuity.

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