EVIDENCE OF COVERAGE

Your Medicare Health Benefits and Services as a Member of

WHA Care+

UNIVERSITY OF CALIFORNIA

January 1 – December 31, 2005

This booklet gives the details about your Medicare health coverage and explains how to get the care you need. This booklet is an important legal document.
Please keep it in a safe place.

PLACER, SACRAMENTO, SOLANO AND YOLO COUNTIES

Welcome to WHA *Care*+!

We are pleased that you've chosen WHA *Care*+.

WHA *Care*+ is an HMO for people with Medicare

Now that you are enrolled in WHA *Care*+, you are getting your care through Western Health Advantage. WHA *Care*+, an HMO, is offered by WHA. **(WHA *Care*+ is *not* a "Medigap" or supplemental Medicare insurance policy.)**

This booklet explains how to get your Medicare services through WHA *Care*+.

This booklet, together with your enrollment form and any amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a member of WHA *Care*+. It also explains our responsibilities to you. The information in this booklet is in effect for the time period from January 1, 2005, through December 31, 2005.

You are still covered by Original Medicare, but you are getting your Medicare services as a member of WHA *Care*+. This booklet gives you the details, including:

- What is covered in WHA *Care*+ and what is not covered.
- How to get the care you need, including some rules you must follow.
- What you will have to pay for your health plan and when you get care.
- What to do if you are unhappy about something related to getting your covered services.
- How to leave WHA *Care*+, including your choices for continuing Medicare if you leave.

Please tell us how we're doing

We want to hear from you about how well we are doing as your health plan. You can call or write to us at any time (Section 1 of this booklet tells how to contact us). Your comments are always welcome, whether they are positive or negative. From time to time, we do surveys that ask our members to tell about their experiences with WHA *Care*+. If you are contacted, we hope you will participate in a member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

Plan Changes for 2005

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

General changes throughout the booklet:

- Annuitant changed to retiree
- Survivor annuitant changed to survivor

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

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SECTION 1. Telephone numbers and other information for reference

How to contact WHA Member Services

If you have any questions or concerns, please call or write to WHA Member Services. We will be happy to help you. Our business hours are Monday through Friday, 8:00 a.m. to 5:00 p.m.

CALL	1-888-563-2252. Calls to this number are free.
TTY	1-888-877-5378. This number requires special telephone equipment. Calls to this number are free.
FAX	1-916-568-0126
WRITE	WHA, 1331 Garden Highway, Suite 100, Sacramento, CA 95833
	Our e-mail address is: **memberservices@westernhealth.com**.
VISIT	www.westernhealth.com

How to contact the Medicare program and the 1-800-MEDICARE (TTY 1-877-486-2048) helpline, 24 hours a day, 7 days a week

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). CMS is the federal agency in charge of the Medicare program. CMS stands for **C**enters for **M**edicare & Medicaid **S**ervices. The CMS contracts with and regulates Medicare Health Plans (including WHA) and Medicare Private Fee-for-Service organizations.

Here are ways to get help and information about Medicare from CMS:

- Call **1-800-MEDICARE** (1-800-633-4227), 24 hours a day, 7 days a week, to ask questions or get free information booklets from Medicare. You can call this national Medicare helpline 24 hours a day, 7 days a week. The TTY number is 1-877-486-2048 (you need special telephone equipment to use this number). Calls to these numbers are free.
- Use a computer to look at www.medicare.gov, the official **government website for Medicare information.** This website gives you a lot of up-to-date information about Medicare and nursing homes. It includes booklets you can print directly from your

computer. It has a tool to help you compare Medicare managed care plans in your area. You can also search the "Helpful Contacts" section for the Medicare contacts in your state. If you do not have a computer, your local library or senior center may be able to help you visit this website using their computer.

HICAP – *an organization in your state that provides free Medicare help and information*

"HICAP" stands for **H**ealth **I**nsurance **C**ounseling and **A**dvocacy **P**rogram. HICAP is a state organization paid by the Federal Government to give free health insurance information and help to people with Medicare. HICAP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. HICAP has information about Medicare managed care plans and about Medigap (Medicare supplement insurance) policies. This includes information about special Medigap rights for people who have tried a Medicare Advantage plan (like WHA *Care*+) for the first time. (Medicare Advantage is the new name for Medicare + Choice.) Section 13 has more information about your Medigap guaranteed issue rights.

You can contact HICAP at 2862 Arden Way, Suite 200, Sacramento, CA 95825 or call 1-800-424-0222. You can also find the website for HICAP at www.medicare.gov on the web.

Lumetra / Quality Improvement Organization – *a group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare*

"QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and other health care experts paid by the Federal Government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. In California, the QIO is called Lumetra. The doctors and other health experts in Lumetra review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency or comprehensive outpatient rehabilitation stay is ending too soon. See Section 11 for more information about complaints.

You can contact Lumetra at: One Sansome Street, Suite 600, San Francisco, CA 94104-4448, or call 1-800-841-1602, TTD 1-800-881-5980.

Other organizations (including Medi-Cal, Social Security Administration)

Medi-Cal agency – a state government agency that handles health care programs for people with low incomes

Medi-Cal is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medi-Cal. Most health care costs are covered if you qualify for both Medicare and Medi-Cal. Medi-Cal also has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medi-Cal and its programs, contact:

Placer County: Health and Human Services
11519 B Avenue
Auburn, CA 95603
(530) 889-7610

100 Stonehouse Court, Suite A
Roseville, CA 95678
(916) 784-6000
www.placer.ca.gov/hhs/hhs.htm

Sacramento County: Department of Human Assistance
2433 Marconi Avenue
Sacramento, CA 95821-4807
(916) 874-2072

Solano County: Health and Social Services
201 Georgia Street
P O Box 12000
Vallejo, CA 94590
(707) 553-5311
www.co.solano.ca.us/hss

Yolo County: Department of Employment and Social Services
25 N. Cottonwood Street
Woodland, CA 95695
(530) 661-2750
www.yolocounty.org/org/dess

Social Security Administration

The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits; disability; family benefits; survivors' benefits; and benefits for the aged, blind, and disabled. You can call the Social Security Administration at 1-800-772-1213. The TTY number is 1-800-325-0778 (you need special telephone equipment to use this number). Calls to these numbers are free. You can also visit www.ssa.gov on the web.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you can call your local Railroad Retirement Board office or 1-800-808-0772 (calls to this number are free). The TTY number is 312-751-4701 (you need special telephone equipment to use this number). You can also visit www.rrb.gov on the web.

Employer (or "Group") Coverage

If you get your benefits from your current or former employer, or your spouse's current or former employer, call the employer's benefits administrator if you have any questions about your benefits, plan premiums, or the open enrollment season.

SECTION 2 Eligibility, Enrollment Termination and Plan Administration Provisions

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

ELIGIBILITY

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

To be eligible to enroll with WHA:

All subscribers and dependents must live or work within a WHA licensed zip code, meaning that either their primary workplace or primary residence is within a WHA licensed zip code. See zip code listing in Section 3. Subscribers must also fulfill their employers' eligibility requirements.

A “primary residence” is defined as one in which the Subscriber and any covered Dependents permanently and physically reside in the residence, no less than eight (8) continuous months out of the calendar year.

Subscriber

Employee: You are eligible if you are appointed to work at least 50% time for twelve months or more or are appointed at 100% time for three months or more or have accumulated 1,000***** hours while on pay status in a twelve-month period. To remain eligible, you must maintain an average regular paid time****** of at least 17.5 hours per week and continue in an eligible appointment. If your appointment is at least 50% time, your appointment form may refer to the time period as follows: "Ending date for funding purposes only; intent of appointment is indefinite (for more than one year)."

* Lecturers - see your benefits office for eligibility.

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

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

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

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

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

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

Retiree (including Survivor):

Retiree A former University Employee receiving monthly benefits from a University-sponsored defined benefit plan.

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

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

(a) you meet the University's service credit requirements for Retiree medical eligibility;

(b) the effective date of your Retiree status is within 120 calendar days of the date employment ends (or the date of the Employee/Retiree's death for a Survivor); and

(c) you elect to continue medical coverage at the time of retirement.

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

Eligible Dependents (Family Members)

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

Spouse: Your legal spouse.

Child: All eligible children must be under the limiting age (18 for legal wards, 23 for all others), unmarried, and may not be emancipated minors. The following categories are eligible:

(a) your natural or legally adopted children;

(b) your stepchildren (natural or legally adopted children of your spouse) if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;

(c) grandchildren of you or your spouse if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;

(d) children for whom you are the legal guardian if living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.

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

- the incapacity began before age 23, the child was enrolled in a group medical plan before age 23 and coverage is continuous;
- the child is claimed as your dependent for income tax purposes or is eligible for Social Security Income or Supplemental Security Income as a disabled person or working in supported employment which may offset the Social Security or Supplemental Security Income; and
- the child lives with you if he or she is not your or your spouse's natural or adopted child.

Application must be made to the Plan at least 31 days before the child's 23rd birthday and is subject to approval by the Plan. The Plan may periodically request proof of continued disability. Incapacitated children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required.

If you are a newly hired Employee with an incapacitated child, you may also apply for coverage for that child. The child must have had continuous group medical coverage since age 23, and you must apply for University coverage during your Period of Initial Eligibility.

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

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

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

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

No Dual Coverage

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

ENROLLMENT

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

During a Period of Initial Eligibility (PIE)

A PIE ends 31 days after it begins.

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

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

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

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

(c) For an adopted child, the earlier of:

(i) the date you or your Spouse has the legal right to control the child's health care, or

(ii) the date the child is placed in your physical custody.

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

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

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

If you are in an HMO, POS or EPO Plan and you move or are transferred out of that Plan's service area, or will be away from the Plan's service area for more than two months, you will have a PIE to enroll yourself and your eligible Family Members in another University medical plan. Your PIE starts with the effective date of the move or the date you leave the Plan's service area.

At Other Times For Employees And Retirees

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

If you are an Employee and opt out of medical coverage or fail to enroll yourself during a PIE or open enrollment period, you may enroll yourself at any other time upon completion of a 90 consecutive calendar day waiting period.

If you are an Employee or Retiree and fail to enroll your eligible Family Members during a PIE or open enrollment period, you may enroll your eligible Family Members at any other time upon completion of a 90 consecutive calendar day waiting period.

The 90-day waiting period starts on the date the enrollment form is received by the local Accounting or Benefits office and ends 90 consecutive calendar days later.

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

If you are a Retiree, you may continue coverage for yourself and your enrolled Family Members in the same plan you were enrolled in immediately before retiring. You must elect to continue enrollment for yourself and enrolled Family Members before the effective date of retirement (or the date disability or survivor benefits begin).

If you are a Survivor, you may not enroll your legal spouse or domestic partner.

Effective Date

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

If you enroll during a PIE, coverage for you and your Family Members is effective the date the PIE starts.

If you are a Retiree continuing enrollment in conjunction with retirement, coverage for you and your Family Members is effective on the first of the month following the first full calendar month of retirement income.

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

For enrollees who complete a 90-day waiting period, coverage is effective on the 91st consecutive calendar day after the date the enrollment transaction is completed.

An Employee or Retiree already enrolled in adult plus child(ren) or family coverage may add additional children, if eligible, at any time after their PIE. Retroactive coverage is limited to the later of:

(a) the date the Child becomes eligible, or

(b) a maximum of 60 days prior to the date your Child's enrollment transaction is completed.

Change in Coverage

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

Effect of Medicare on Retiree Enrollment

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

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

Part A will be required. (Retirees/Family Members who are not entitled to Social Security and premium free Medicare Part A will not be required to enroll in Part B.)

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

Upon Medicare eligibility, you or your Family Member must complete a University of California Medicare Declaration form as well as submit a copy of your Medicare card. This notifies the University that you are covered by Part A and Part B of Medicare. The University's Medicare Declaration forms are available through the University's Customer Service Center. Completed forms should be returned to University of California, Human Resources and Benefits, Health & Welfare Administration – Retiree Insurance Program, Post Office Box 24570, Oakland, CA 94623-9911.

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

Medicare Secondary Payer Law (MSP)

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

employment, Medicare becomes the secondary payer and the employer plan becomes the primary payer.

Medicare Private Contracting Provision

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

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

However, if you do sign a private contract with a physician or practitioner, you may see other

physicians or practitioners without those private contract restrictions as long as they have not opted out of Medicare.

TERMINATION OF COVERAGE

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

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 a Retiree or Survivor and your annuity terminates, your coverage and that of any enrolled Family Member stops at the end of the last month in which you are eligible for an annuity.

If your Family Member loses eligibility, you must complete the appropriate transaction to delete him or her within 60 days of the date the Family Member is no longer eligible. Coverage stops at the end of the month in which he or she no longer meets all the eligibility requirements. For information on deenrollment procedures, contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

Deenrollment Due to Fraud

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

Leave of Absence, Layoff or Retirement

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

Optional Continuation of Group Coverage

If your coverage or that of a Family Member ends, you and/or your Family Member may be entitled to elect continued coverage under the terms of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended and if that continued coverage ends, specified individuals may be eligible for further continuation under California law. The terms of these continuation provisions are contained in the University of California notice "Continuation of Group

Insurance Coverage", available from the University's "At Your Service" website (http://atyourservice.ucop.edu). The notice is also available from the person in your department who handles benefits and from the University's Customer Service Center. You may also direct questions about these provisions to your local Benefits Office or to the University's Customer Service Center if you are a Retiree.

PLAN ADMINISTRATION

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

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

Sponsorship and Administration of the Plan

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

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

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

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

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

Group Contract Number

The Group Contract Number for this Plan is: 00-1021

Type of Plan

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

Plan Year

The plan year is January 1 through December 31.

Continuation of the Plan

The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. Plan benefits are not accrued or vested benefit entitlements. The right to terminate or amend applies to all Employees, Retirees and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, premiums and what portion of the premiums the University will pay. The portion of the premiums that University pays is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation.

Financial Arrangements

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

Agent for Serving of Legal Process

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

Your Rights under the Plan

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

Examine, without charge, at the Plan Administrator's office and other specified sites, all Plan documents, including the Group Service Agreement, at a time and location mutually convenient to the participant and the Plan Administrator.

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

Claims under the Plan

To file a claim, refer to Section 9, or to appeal a denied claim, refer to Section 11 of this document.

Nondiscrimination Statement

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

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

SECTION 3 Getting the care you need, including some rules you must follow

What is WHA *Care+?*

Now that you are enrolled in WHA *Care+*, you are getting your Medicare through Western Health Advantage (WHA). WHA *Care+* is offered by WHA, and is an HMO for people with Medicare. The Medicare program pays us to manage health services for people with Medicare who are members of WHA *Care+*. (WHA *Care+* is **not** a Medicare supplement policy. See Section 15 for a definition of Medicare supplement policy. Medicare supplement policies are sometimes called "Medigap" insurance policies.) WHA provides medical services through Medicare-certified health care facilities. In addition, our health care professionals are in compliance with Medicare credentialing standards.

This booklet explains your benefits and services, what you have to pay, and the rules you must follow to get your care. WHA *Care+* gives you all of the usual Medicare services that are covered for everyone with Medicare.

Since WHA *Care+* is a Medicare HMO, this means that you will be getting most or all of your health services from the doctors, hospitals, and other health providers that are part of WHA *Care+*. Since these doctors, hospitals, and other providers are the ones we are paying to provide your care, they are the ones you must use (except in special situations such as emergencies).

Use your plan membership card instead of your red, white, and blue Medicare card

Now that you are a member of WHA *Care*+, you have a WHA *Care*+ membership card. Here is a sample card to show what it looks like:

WHA Care+ Membership ID Card

SAMPLE

WHA Western Health Advantage *Care*+ ID CARD **Rx# WHAMED9** NAME: JOHN DOE ID #: 00000000000 PCP: NAME OF DOCTOR PCP PHONE: 916-XXX-XXXX MED GRP: UCDMG COVERAGE EFF: 01-01-03 GROUP: OFFICE: PLAN #: ER:	**Emergency Services: If you believe an emergency situation exists, call 911 or go to the nearest emergency room.** Notify your Primary Care Physician of all emergency care within 24 hours or as soon as possible. Your physician's telephone number is listed on the front of this card. **Members:** You must establish yourself with your Primary Care Physician. In order for services to be paid you must follow WHA's benefit guidelines. Please read your Combined Evidence of Coverage and Disclosure Form for plan details. **Providers:** You must obtain prior authorization for all scheduled hospital and all non-emergency treatment outside of WHA's service area. This card is for identification purposes only. It does verify eligibility. **Pharmacists:** Submit claims via TelePAID System only for the person for whom the prescription was written. For assistance, Pharmacists may call 1-800-922-1557. Bin# 610014 **Western Health Advantage** WHA Care+, 1331 Garden Highway, Suite100 Sacramento, CA 95833 (916) 563-2252 (888) 563-2252/ TTY (888)877-5378 or visit us at www.westernhelath.com
FRONT	**BACK**

During the time you are a plan member and using plan services, **you *must* use your plan membership card instead of your red, white, and blue Medicare card to get covered services.** (See Section 5 for a definition and list of covered services.) Keep your red, white, and blue Medicare card in a safe place in case you are asked to show it, but for the most part you will not use it to get services while you are a member. If you get covered services using your red, white and blue Medicare card instead of your WHA *Care*+ membership card while you are a plan member, the Medicare program will not pay for these services and you may have to pay the full cost yourself.

Please carry your WHA *Care*+ membership card with you at all times. You will need to show this card when you get covered services. You will also need it to get your prescriptions at the pharmacy. If your membership card is ever damaged, lost, or stolen, call Member Services right away and we will send you a new card.

Help us keep your membership record up to date

WHA has a file of information about you as a plan member. Doctors, hospitals, and other plan providers use this membership record to know what services are covered for you. The membership record has information from your enrollment form, including your address and telephone number. It shows your specific WHA *Care*+ coverage, the Primary Care Physician and the Medical Group you chose when you enrolled, and other information. Section 10 tells how we protect the privacy of your personal health information.

Please help us keep your membership record up to date by letting Member Services know right away if there are any changes in your name, address, or phone number, or if you go into a nursing home. Also, tell Member Services about any changes in health insurance coverage you have from other sources, such as from your employer, your spouse's employer, workers' compensation, Medi-Cal, or liability claims such as claims against another driver in an automobile accident. See Section 1 for how to contact Member Services.

What is the geographic service area for WHA *Care+?*

The counties, and parts of counties, in our service area are listed below, by zip code.

(* Indicates a partial county)

Placer County*:	**95650**	**95661**	**95677**	**95678**
	95746	**95747**	**95765**	
Sacramento County:	**All zip codes**			
Solano County*:	**94512**	**94533**	**94534**	**94535**
	94571	**94585**	**95620**	**95625**
	95687	**95688**	**95696**	
Yolo County:	**All zip codes**			

Using plan providers to get services covered by WHA *Care+*

You will be using plan providers to get your covered services.

Now that you are a member of WHA *Care+*, with few exceptions, **you must use plan providers to get your covered services.**

- **What are "plan providers"?** "Providers" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "plan providers" when they participate in WHA *Care+*. When we say that plan providers "participate in WHA *Care+*," this means that we have arranged with them to coordinate or provide covered services to members of WHA *Care+*.
- **What are "covered services"?** "Covered services" is the general term we use in this booklet to mean all of the health care services and supplies that are covered by WHA *Care+*. Covered services are listed in the Benefits Chart in Section 5.

As we explain below, you will have to choose one of our plan providers to be your PCP, which stands for Primary Care Physician. Your PCP will provide or arrange for most or all of your covered services. Care or services you get from non-plan providers will not be covered, with few exceptions such as emergencies. (When we say "non-plan providers**,**" we mean providers that are **not** part of WHA *Care+.*)

The Provider Directory gives you a list of plan providers

Every year as long as you are a member of WHA *Care+,* we will send you a Provider Directory, which gives you a list of plan providers. If you don't have the Provider Directory, you can get a copy from Member Services (call the number displayed in Section 1 of this booklet). You may also note that a complete list of plan providers is available on our website: www.westernhealth.com. You can ask Member Services for more information about plan providers, including their qualifications and experience. Member Services can give you the most up-to-date information about changes in plan providers and about which ones are accepting new patients.

Access to care and information from plan providers

You have the right to get timely access to plan providers and to all services covered by the plan. ("Timely access" means that you can get appointments and services within a reasonable period of time.) You have the right to get full information from your doctors when you go for medical care. You have the right to participate fully in decisions about your health care, which includes the right to refuse care. Please see Section 10 for more information about these and other rights you have, and what you can do if you think your rights have not been respected.

Choosing Your PCP (PCP means Primary Care Physician)

What is a "PCP"?

When you become a member of WHA *Care+,* you must choose a plan provider to be your PCP. "PCP" stands for **Primary Care Physician**. Your PCP is a physician who meets State requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a plan member. For example, in order to see a specialist, you usually need to get your PCP's approval first (this is called getting a "referral" to a specialist).

How do you choose a PCP?

There are several reliable ways to find out about Primary Care Physicians in your community. Ask local friends and neighbors about their relationship with their doctors. Listening to the opinions of family and friends is still one of the most common ways to find a doctor you like and trust.

The WHA *Care+* Provider Directory is also a valuable resource for selecting the Primary Care Physician who is right for you. Included are family practice physicians, internal medicine physicians and general medicine physicians. At certain locations the physician or his/her staff may speak other languages in addition to English. If applicable, those languages will be listed next to the physician's address.

Because a physician may not always be able to accept new patients, you should always contact the doctor's office to verify whether the doctor has openings in his/her practice.

If you are currently receiving care, or are an established patient of a Primary Care Physician listed in the WHA *Care+* Provider Directory, you are not considered a new patient and will be able to continue treatment.

If you need assistance finding or changing your Primary Care Physician, please call the Member Services Department at 1-**916-563-2252, 1-888-563-2252 or TTY 1-888-877-5378, Monday through Friday, 8 a.m. to 5 p.m.**

If there is a particular WHA *Care+* specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist, or uses that hospital.

The name and office telephone number of your PCP is printed on your membership card.

Getting care from your PCP

You will usually see your PCP first for most of your routine health care needs. As we explain below and in Section 5, there are only a few types of covered services you can get on your own, without contacting your PCP first.

Besides providing much of your care, your PCP will help arrange or coordinate the rest of the covered services you get as a plan member. This includes your x-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions, and follow-up care. "Coordinating" your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, your PCP must give approval in advance (such as giving you a referral to see a specialist). In some cases, your PCP will also

need to get prior authorization (prior approval). Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your new PCP's office. Section 10 tells how we will protect the privacy of your medical records and personal health information.

What if you need medical care when your PCP's office is closed?

What to do if you have a medical emergency or urgent need for care

In an emergency, you should get care immediately. You do **not** have to contact your PCP or get permission in an emergency. You can dial 911 for immediate help by phone, or go directly to the nearest emergency room, hospital, or urgent care center. Section 4 tells what to do if you have a medical emergency or urgent need for care.

What to do if it is not a medical emergency

If you need to talk with your PCP or get medical care when the PCP's office is closed, and it is *not* a medical emergency, call your PCP's office. You can call your PCP at any time of the day, including evenings and weekends. Explain your condition to your doctor or the Physician on-call and they will direct your care. There will always be a doctor on call to help you. This physician will call you back and advise you about what to do.

See Section 4 for more information about what to do if you have an urgent need for care. Keep in mind that **if you have an urgent need for care while you are in the service area, we expect you to get this care from plan providers.** In most cases, we will not pay for urgently needed care that you get from a *non-plan provider* while you are in the plan's service areas. (Our service area is listed earlier in this Section.)

Getting care from specialists

When your PCP thinks that you need specialized treatment, he or she will give you a referral (approval in advance) to see a plan specialist. A specialist is a doctor who provides health care services for a specific disease or part of the body. Examples include oncologists (who care for patients with cancer), cardiologists (who care for patients with heart conditions), and orthopedists (who care for patients with certain bone, joint, or muscle conditions). For some types of referrals to plan specialists, your PCP may need to get approval in advance from their medical group or the WHA *Care*+ Medical Management Department (this is called getting "prior authorization").

It is very important to get a referral from your PCP before you see a plan specialist (there are a few exceptions, including routine women's health care, that we explain later in this section). **If you don't have a referral before you receive services from a specialist, you may have to pay for these services yourself.** If the specialist wants you to come back for more care, check first to be sure that the referral you got from your PCP covers more visits to the specialist.

If there are specific specialists you want to use, find out whether your PCP sends patients to these specialists. Each plan PCP has certain plan specialists they use for referrals. This means that **the WHA *Care*+ specialists you can use may depend on which person you chose to be your PCP.** You can change your PCP at any time if you want to see a plan specialist that your

current PCP cannot refer you to. Later in this section, under "Choosing your PCP," we tell you how to change your PCP. If there are specific hospitals you want to use, find out whether your PCP uses these hospitals.

In order to expand the choice of specialists, WHA has implemented a unique program called the **Advantage Referral Program.** This program allows access to all specialists in our network rather than just those who have a direct relationship with your Primary Care Physician. If he or she determines that your medical condition requires specialty care, you will be referred to any of the WHA *Care*+ network specialists. Self-referred annual well-woman exams, obstetrical services and mammograms 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 *Care*+ Provider Directory.

In most cases, you will be comfortable with the specialist that your Primary Care Physician selects; however, if you already have a relationship with a network specialist, or prefer another network specialist, you may ask to be referred to him or her instead. The WHA *Care*+ Provider Directory lists all of the network specialists approved for referrals by your Primary Care Physician. Any provider not listed in the WHA *Care*+ Provider Directory is a *non-participating provider*, and you must obtain prior authorization from WHA before obtaining services.

Please be sure to consult with your PCP if there are specific specialists or facilities that you want to use.

There are some services you can get on your own, without a referral

As explained above, you will get most of your routine or basic care from your PCP, and your PCP will coordinate the rest of the covered services you get as a plan member. If you get services from any doctor, hospital, or other health care provider without getting a referral in advance from your PCP, you may have to pay for these services yourself – even if you get the services from a plan provider. *But there are a few exceptions:* you can get the following services on your own, without a referral or approval in advance from your PCP. This is called "**self-refer**" when you get these services on your own. You still have to pay your copayment for these services.

- Routine women's health care, which includes breast exams, mammograms (x-rays of the breast), pap tests, and pelvic exams. This care is covered without a referral from your PCP *only* if you get it from a plan provider.
- Flu shots and pneumonia vaccinations (as long as you get them from a plan provider).
- Routine eye exam (as long as you get them from a plan provider).
- Emergency services, whether you get these services from plan providers or non-plan providers (see Section 4 for more information).
- Urgently needed care that you get from non-plan providers when you are temporarily outside the plan's service area. Also, urgently needed care that you get from non-plan providers when you are in the service area but, because of unusual or extraordinary circumstances, the plan providers are temporarily unavailable or inaccessible. (See

  Section 4 for more information about urgently needed care. Earlier in this section, we explain the plan's service area.)

- Renal dialysis (kidney) services that you get when you are temporarily outside the plan's service area. If possible before you leave, please let us know where you are going to be so we can help arrange for you to have maintenance dialysis while outside the service area.

Getting care when you travel or are away from the plan's service area

If you need care when you are outside the service area, your coverage is very limited. The only services we cover when you are outside our service area are care for a medical emergency, urgently needed care, renal dialysis, and care that WHA *Care*+ or a plan provider has approved in advance. See Section 4 for more information about care for a medical emergency and urgently needed care. If you have questions about what medical care is covered when you travel, please call Member Services at the telephone number displayed in Section 1 of this booklet.

How to change your PCP

You may change your PCP for any reason, at any time. To change your PCP, call Member Services at the number displayed in Section 1 of this booklet.

When you call, be sure to tell Member Services if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and durable medical equipment). Member Services will help make sure that you can continue with the specialty care and other services you have been getting when you change to a new PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. Member Services will change your membership record to show the name of your new PCP and tell you when the change to your new PCP will take effect. They will also send you a new membership card that shows the name and phone number of your new PCP.

What if your doctor leaves WHA *Care+?*

Sometimes a PCP, specialist, clinic, or other plan provider you are using might leave the plan. If this happens, you will have to switch to another provider who is part of WHA *Care*+. If your PCP leaves WHA *Care*+, we will let you know, and help you switch to another PCP so that you can keep getting covered services.

SECTION 4 Getting care if you have a medical emergency or an urgent need for care

What is a "medical emergency"?

A "medical emergency" is when **you reasonably believe that your health is in serious danger** -- when every second counts. A medical emergency includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting much worse.

What should you do if you have a medical emergency?

If you have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room. **You do not need to get permission first from your PCP (Primary Care Physician) or other plan provider.** (Section 3 tells about your PCP and plan providers.)
- Make sure that WHA *Care*+ knows about your emergency, because we will need to be involved in following up on your emergency care. You or someone else should call to tell WHA *Care*+ about your emergency care as soon as possible, preferably within 48 hours. Call the phone number on the back of the membership card.

WHA *Care+ will help manage and follow up on your emergency care*

WHA *Care*+ will talk with the doctors who are giving you emergency care to help manage and follow up on your care. When the doctors who are giving you emergency care say that your condition is stable and the medical emergency is over, what happens next is called "post-stabilization care". Your follow-up care (post-stabilization care) will be covered according to Medicare guidelines. In general, we will try to arrange for plan providers to take over your care as soon as your medical condition and the circumstances allow.

What is covered if you have a medical emergency?

- You can get covered emergency medical care whenever you need it, anywhere in the world.
- **Ambulance** services are covered in situations where other means of transportation would endanger your health.

What if it wasn't really a medical emergency?

Sometimes it can be hard to know if you have a real medical emergency. For example, you might go in for emergency care -- thinking that your health is in serious danger -- and the doctor may say that it was not a medical emergency after all. If this happens to you, you are still covered for the care you got to determine what was wrong (as long as you thought your health was in serious danger, as explained in "What is a 'medical emergency'" above). However, please note that:

- If you get any additional care after the doctor says it was *not* a medical emergency, we will pay our portion of the covered additional care **if you get it from a plan provider**
- If you get any additional care from a *non-plan provider* after the doctor says it was not a medical emergency, we will usually *not* cover the additional care. There is an exception: we will pay our portion of the covered additional care from a non-plan provider if you are out of our service area, as long as the additional care you get meets the definition of "urgently needed care" that is given below.

What is "urgently needed care"? (this is different from a medical emergency)

"Urgently needed care" is **when you need medical attention right away for an unforeseen illness or injury,** and it is not reasonable given the situation for you to get medical care from your PCP or other plan providers. In these cases, your health is *not* in serious danger. As we explain below, how you get "urgently needed care" depends on whether you need it when you are in the plan's service area, or outside the plan's service area. Section 3 tells about the plan's service area.

What is the difference between a "medical emergency" and "urgently needed care"?

The main difference between an urgent need for care and a medical emergency is in the danger to your health. "Urgently needed care" is if you need medical help immediately, but your health is not in serious danger. A "medical emergency" is if you believe that your health is in serious danger.

Getting urgently needed care when you are <u>in</u> the plan's service area

If you have a sudden illness or injury that is not a medical emergency, and you are in the plan's service area, please call your PCP.

You can call your PCP at any time of the day, including evenings and weekends. Explain your condition to your doctor or the physician on-call, and they will direct your care. There will always be a doctor on call to help you. This physician will call you back and advise you about what to do.

Keep in mind that if you have an urgent need for care while you are in the plan's service area, we expect you to get this care from plan providers. In most cases, we will not pay for urgently needed care that you get from a *non-plan provider* while you are in the plan's service area.

Getting urgently needed care when you are <u>outside</u> the plan's service area

WHA *Care*+ covers urgently needed care that you get from non-plan providers when you are outside the plan's service area. If you need urgent care while you are outside the plan's service area, we prefer that you call your PCP first, whenever possible. If you are treated for an urgent care condition while out of the service area, we prefer that you return to the service area to get follow-up care through your PCP. However, we will cover follow-up care that you get from non-plan providers outside the plan's service area as long as the care you are getting still meets the definition of "urgently needed care."

As explained in Section 3, we cover renal (kidney) dialysis services that you get when you are temporarily outside the plan's service area (for up to six months in a row).

SECTION 5 Benefits Chart – a list of the covered services you get as a member of WHA *Care*+

What are "covered services"?

This section describes the medical benefits and coverage you get as a member of WHA *Care*+. **"Covered services" means the medical care, services, supplies, and equipment that are covered by WHA *Care*+.** This section has a Benefits Chart that gives a list of your covered services and tells what you must pay for each covered service. The section that follows (Section 6) tells about **services that are *not* covered** (these are called "exclusions").

There are some conditions that apply in order to get covered services

Some general requirements apply to *all* covered services

The covered services listed in the Benefits Chart in this section are covered only when *all* requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare program.
- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary. Certain preventive care and screening tests are also covered. (See Section 15 for a definition of "medically necessary".)
- With few exceptions, covered services must either be provided by plan providers, be approved in advance by plan providers, or be authorized by WHA *Care*+. The exceptions are care for a medical emergency, urgently needed care, and renal (kidney) dialysis you get when you are outside the plan's service area.

In addition, some covered services require "prior authorization" in order to be covered

Some of the covered services listed in the Benefits Chart in this section are covered only if your doctor or other plan provider gets "prior authorization" (approval in advance) from WHA *Care+.* Covered services that need prior authorization are marked in the Benefits Chart.

WHA *Care+ Benefits Chart – a list of covered services*

WHA *Care+* Benefits Chart – Your covered services	**What you must pay** when you get these covered services
INPATIENT SERVICES	
Inpatient hospital care For more information about hospital care, see Section 8. **You are covered for unlimited days each benefit period.** Covered services include, but are not limited to, the following: ▪ Semiprivate room (or a private room if medically necessary). ▪ Meals including special diets. ▪ Regular nursing services. ▪ Costs of special care units (such as intensive or coronary care units). ▪ Drugs and medications. ▪ Lab tests. ▪ X-rays and other radiology services. ▪ Necessary surgical and medical supplies. ▪ Use of appliances, such as wheelchairs. ▪ Operating and recovery room costs. ▪ Rehabilitation services, such as physical therapy, occupational therapy, and speech therapy services. ▪ *Under certain conditions, the following types of transplants are covered:* corneal, kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, intestinal/multivisceral. See Section 8 for more information about transplants. ▪ Blood - Coverage begins with the fourth pint of blood that you need – you pay for the first 3 pints of unreplaced blood. Coverage of storage and administration begins with the first pint of blood that you need. ▪ Physician Services. ***Except in an emergency, you must get prior authorization from Western Health Advantage before you get this service. Failure to get authorization can result in significantly higher costs to you. Contact your plan for details.***	You pay **$250** for each Medicare-covered stay in a network hospital. In WHA *Care+*, a per admission deductible is applied once during a benefit period. If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, you are responsible for full cost. A **benefit period** begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital copayment for each benefit period. There is no limit to the number of benefit periods you can have.

WHA *Care+* Benefits Chart – Your covered services	**What you must pay** when you get these covered services
Inpatient mental health care Includes mental health care services given in a hospital that require a hospital stay. There is a 190-day lifetime limit in a psychiatric hospital. (The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.) ***Except in an emergency, you must get prior authorization from Western Health Advantage before you get this service. Failure to get authorization can result in significantly higher costs to you. Contact your plan for details.***	You pay **$250** for each Medicare-covered stay in a network hospital.
Skilled nursing facility care For more information about skilled nursing facility care, see Section 8. **You are covered for 100 days each benefit period.** **No prior hospital stay is required.** Covered services include, but are not limited to, the following: ▪ Semiprivate room (or a private room if medically necessary). ▪ Meals, including special diets. ▪ Regular nursing services. ▪ Physical therapy, occupational therapy, and speech therapy. ▪ Drugs (this includes substances that are naturally present in the body, such as blood clotting factors). ▪ Blood - including storage and administration. Coverage begins with the fourth pint of blood that you need – you pay for the first 3 pints of unreplaced blood. ▪ Medical and surgical supplies. ▪ Laboratory tests. ▪ X-rays and other radiology services. ▪ Use of appliances such as wheelchairs. ▪ Physician services. ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.***	There is **no copayment** for services in a Skilled Nursing Facility. A **benefit period** begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital copayment for each benefit period. There is no limit to the number of benefit periods you can have.

WHA *Care+* Benefits Chart – Your covered services	**What you must pay** when you get these covered services
Inpatient services (when the hospital or SNF days are not or are no longer covered) For more information, see Section 8. ▪ Physician services. ▪ Diagnostic tests (like X-ray or lab tests). ▪ X-ray, radium, and isotope therapy including technician materials and services. ▪ Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations. ▪ Prosthetic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices. ▪ Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition. ▪ Physical therapy, speech therapy, and occupational therapy. ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.***	You pay **$10** for each primary care doctor visit for Medicare-covered services. There is **no copayment** for Medicare-covered diagnostic tests, X-ray, radium, isotope therapy, surgical splints, casts (and other devices used to reduce fractures and dislocations), prosthetic devices, braces, trusses, artificial legs, arms and eyes. You pay **$10** for each Medicare-covered physical therapy and/or speech/ occupational therapy visit.
Home health care For more information about home health care, see Section 8. **Home Health Agency Care:** ▪ Part-time or intermittent skilled nursing and home health aide services. ▪ Physical therapy, occupational therapy, and speech therapy. ▪ Medical social services. ▪ Medical equipment and supplies. ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.***	There is **no copayment** for Medicare-covered home health visits.

WHA *Care+* Benefits Chart – Your covered services	**What you must pay** when you get these covered services
Hospice care For more information about hospice services, see Section 8. ▪ Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Medicare. ▪ Home care. ▪ Hospice consultation services (one time only) for a terminally ill individual who has not yet elected the hospice benefit. ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.***	When you enroll in a Medicare-certified hospice, your hospice services are paid by Medicare (see Section 8 for more information about hospice services).
OUTPATIENT SERVICES	
Physician services, including doctor office visits ▪ Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center. ▪ Consultation, diagnosis, and treatment by a specialist. ▪ Second opinion by another plan provider prior to surgery. ▪ Outpatient hospital services. ▪ Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor). ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.***	You pay **$10** for each primary care doctor office visit for Medicare-covered services.
Chiropractic services ▪ Manual manipulation of the spine to correct subluxation. ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.***	You pay **$10** for each Medicare-covered visit.
Podiatry services ▪ Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). ▪ Routine foot care for members with certain medical conditions affecting the lower limbs. ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.***	You pay **$10** for each Medicare-covered visit (medically necessary for foot care).

WHA *Care+* Benefits Chart – Your covered services	**What you must pay** when you get these covered services
Outpatient mental health care (including Partial Hospitalization Services) Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other mental health care professional as allowed under applicable state laws. "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.***	For Medicare-covered Mental health services, you pay **$10** for each individual/ group therapy visit.
Outpatient substance abuse services ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.***	For Medicare-covered services, you pay **$10** for each individual/ group visit.
Outpatient surgery ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.***	You pay **$10** for each Medicare-covered visit to an ambulatory surgical center. You pay **$10** for each Medicare-covered visit to an outpatient hospital facility.
Ambulance services Includes ambulance services to an institution (like a hospital or SNF), from an institution to another institution, from an institution to your home, and services dispatched through 911, where other means of transportation could endanger your health.	There is no copayment for Medicare-covered ambulance services.

WHA *Care+* Benefits Chart – Your covered services	**What you must pay** when you get these covered services
Emergency care For more information, see Section 4. ▪ Covered inpatient or outpatient services that are: 1) given by a provider qualified to give emergency services; and 2) needed to evaluate or stabilize a medical emergency condition. ▪ Worldwide coverage	If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, you are responsible for the full cost. You pay **$50** for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition.
Urgently needed care For more information, see Section 4. Worldwide coverage.	You pay **$10** for each Medicare-covered urgently needed care visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition.
Outpatient rehabilitation services (physical therapy, occupational therapy, cardiac rehabilitation, and speech and language therapy) Cardiac rehabilitation therapy covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery, and/or have stable angina pectoris. ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.***	You pay **$10** for each Medicare-covered visit.
Durable medical equipment and related supplies --such as wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. (See definition of "durable medical equipment" in Section 15) ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.***	There is no copayment for each Medicare-covered item.

WHA *Care+* Benefits Chart – Your covered services	**What you must pay** when you get these covered services
Prosthetic devices and related supplies--(other than dental) which replace a body part or function. These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" below for more detail. ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.***	There is no copayment for each Medicare-covered item.
Diabetes self-monitoring, training and supplies-- for all people who have diabetes (insulin and non-insulin users). ▪ Blood glucose meter, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors. ▪ One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts. ▪ Self-management training is covered under certain conditions. ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.***	There is **no copayment** for diabetes self-monitoring training. You pay **$10** for each Medicare-covered diabetes supply item.
Medical nutrition therapy—for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor. ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.***	There is **no copayment** for Medicare-covered items.

WHA *Care+* Benefits Chart – Your covered services	**What you must pay** when you get these covered services
Outpatient diagnostic tests and therapeutic services and supplies ▪ X-rays. ▪ Outpatient radiation therapy. ▪ Renal dialysis services (including renal dialysis services when temporarily out of the plan's service area, as explained in Sections 3 and 4). ▪ Surgical supplies, such as dressings. ▪ Supplies, such as splints and casts. ▪ Therapeutic shoes for those with diabetic foot disease. ▪ Laboratory tests. ▪ Blood - Coverage begins with the fourth pint of blood that you need – you pay for the first 3 pints of unreplaced blood. Coverage of storage and administration begins with the first pint of blood that you need. ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.***	There is **no copayment** for Medicare-covered items.
PREVENTIVE CARE AND SCREENING TESTS	
Bone mass measurements *For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary:* procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results. ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.***	There is **no copayment** for each Medicare-covered bone mass measurement.

WHA *Care+* Benefits Chart – Your covered services	**What you must pay** when you get these covered services
Colorectal screening *For people 50 and older, the following are covered:* ▪ Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. ▪ Fecal occult blood test, every 12 months. *For people at high risk of colorectal cancer, the following are covered:* ▪ Screening colonoscopy (or screening barium enema as an alternative) every 24 months. *For people not at high risk of colorectal cancer, the following is covered:* ▪ Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy. ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.***	There is **no copayment** for each Medicare-covered colorectal screening exam.
Immunizations ▪ Pneumonia vaccine. As explained in Section 3, you can get this service on your own, without a referral from your PCP (as long as you get the service from a plan provider). ▪ Flu shots, once a year in the fall or winter. As explained in Section 3, you can get this service on your own, without a referral from your PCP (as long as you get the service from a plan provider). ▪ *If you are at high or intermediate risk of getting Hepatitis B*: Hepatitis B vaccine. ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.*** Other vaccines if you are at risk. ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.***	There is **no copayment** for the pneumonia and flu vaccines.
Mammography screening As explained in Section 3, you can get this service on your own, without a referral from your PCP (as long as you get it from a plan provider): ▪ One baseline exam between the ages of 35 and 39. ▪ One screening every 12 months for women age 40 and older. You are covered for unlimited number of screening mammograms.	There is **no copayment** for: ▪ Medicare-covered screening mammograms. ▪ Additional screening mammograms.

WHA *Care+* Benefits Chart – Your covered services	**What you must pay** when you get these covered services
Pap smears, pelvic exams, and clinical breast exams (as explained in Section 3, you can get these routine women's health services on your own, without a referral from your PCP (as long as you get the services from a plan provider): ▪ For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months. ▪ *If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age:* one Pap test every 12 months.	You pay: ▪ **$0** for each Medicare-covered Pap Smear. ▪ **$0** for each additional Pap Smear up to 1 Pap Smear every year. ▪ **$10** for each Medicare-covered pelvic exam.
Prostate cancer screening exams ***For men over age 50, the following are covered once every 12 months:*** ▪ Digital rectal exam ▪ Prostate Specific Antigen (PSA) test ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.***	There is **no copayment** for: ▪ Medicare-covered prostate cancer screening exams. ▪ Additional screening exam up to 1 exam every year.
"Welcome to Medicare" physical exam *For members whose Medicare Part B coverage begins on or after January 1, 2005:* A one-time physical exam within the first 6 months that you have Medicare Part B. Includes measurement of height, weight and blood pressure; an electrocardiogram; education, counseling and referral with respect to covered screening and preventive services. Does not include lab tests.	See **"Routine physical exams"** for copayment information.

WHA *Care+* Benefits Chart – Your covered services	**What you must pay** when you get these covered services
OTHER SERVICES	
Renal Dialysis (Kidney) ▪ Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Sections 3 and 4). ▪ Inpatient dialysis treatments (if you are admitted to a hospital for special care). ▪ Self-dialysis training (includes training for you and for the person helping you with your home dialysis treatments). ▪ Home dialysis equipment and supplies. ▪ Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies when needed, and check your dialysis equipment and water supply). ▪ Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and Erythropoietin (Epogen ®) or Epoetin alfa.	You pay: **$100** for Medicare-covered outpatient services. **$250** for Medicare-covered inpatient services.

WHA *Care*+ Benefits Chart – Your covered services	**What you must pay** when you get these covered services
Drugs that are covered under Original Medicare (these drugs are covered for everyone with Medicare) "Drugs" includes substances that are naturally present in the body, such as blood clotting factors. ▪ Drugs that usually are not self-administered by the patient and are injected while receiving physician services. WHA *Care*+ also covers some drugs that are "usually not self-administered" even if you inject them at home. ▪ Drugs you take using durable medical equipment (such as nebulizers) that was authorized by WHA *Care*+. (See Section 15 for a definition of "durable medical equipment'.) ▪ Clotting factors you give yourself by injection if you have hemophilia. ▪ Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare. ▪ Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug. ▪ Antigens. ▪ Certain oral anti-cancer drugs and anti-nausea drugs. ▪ Erythropoietin by self-injection if you have end-stage renal disease (permanent kidney failure); receive home dialysis; and need this drug to treat anemia. ▪ Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your residence. Coverage for outpatient prescription drugs is very limited. The drugs covered under Original Medicare are generally drugs that must be administered by a health professional. In addition to the drugs listed here that are covered under Original Medicare, WHA *Care*+ offers an outpatient prescription drug benefit. This additional benefit is described below under the heading that says, "WHA *Care*+ Prescription Drug Benefit (outpatient prescription drugs)". ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.***	There is **no benefit limit** on these drugs covered under Original Medicare.

WHA *Care+* Benefits Chart – Your covered services	**What you must pay** when you get these covered services
ADDITIONAL BENEFITS	
WHA *Care+* Prescription Drug Benefit (outpatient prescription drugs) "Drugs" include substances that are naturally present in the body. **The WHA *Care+* prescription drug benefit covers the following:** ▪ Certain outpatient prescription drugs. Section 7 explains about the prescription drug benefit, including rules you must follow to have prescriptions covered. Section 7 also tells about drugs that are not covered by this benefit. ▪ Ask Western Health Advantage for a copy of our formulary. ▪ You must use designated retail pharmacies and mail order to get your prescription drugs. ▪ Authorization may be required for formulary drugs.	For prescription drugs you pay for each prescription or refill: ▪ **$10** for generic drugs up to a 30-day supply. ▪ **$20** for Brand Name up to a 30-day supply. ▪ **$35** copayment for Non-formulary **Mail-order (90 day supply)** ▪ **$20** copayment for Generic ▪ **$40** copayment for Brand Name ▪ **$70** copayment for Non-formulary
Dental services ▪ Limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor. ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.***	In general, you pay 100% for dental services.
Hearing services ▪ Diagnostic hearing exams. ▪ Routine hearing test up to 1 test every year.	You pay: ▪ **$10** for each Medicare-covered hearing exam diagnostic hearing exams). ▪ **$10** for each routine hearing test up to 1 test every year. ▪ One device per ear every 36 months

WHA *Care+* Benefits Chart – Your covered services	**What you must pay** when you get these covered services
▪ Hearing aids ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.***	every 36 months with a $10 copayment. ($2000 benefit maximum)
Vision care **Outpatient physician services for eye care.** ▪ *For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older:* glaucoma screening once per year. ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.*** ▪ One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.*** ▪ Routine eye exam, limited to 1 exam every year. (As explained in Section 3, you can get this service on your own, without a referral from your PCP, as long as you get it from a plan provider).	There is **no copayment** for Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery). You pay: ▪ **$10** for each Medicare-covered eye exam (diagnosis and treatment for disease and conditions of the eye). ▪ **$10** for each routine eye exam, limited to 1 exam every year.
Routine physical exams You are covered for an unlimited number of exams.	You pay **$10** for each exam.
Health and wellness education programs These are programs focused on clinical health conditions such as hypertension, cholesterol, asthma, and special diets. Programs designed to enrich the health & lifestyles of members include weight management, smoking cessation, fitness & stress management. ***Requires prior authorization (approval in advance) from Western Health Advantage to be covered.***	There is **no copayment** for the following: ▪ Health Ed classes ▪ Newsletter

What if you have problems getting services you believe are covered for you?

If you have any concerns or problems getting the services that you believe are covered for you as a member, we want to help. Please call us at Member Services at the telephone number displayed in Section 1 of this booklet. You have the right to make a complaint if you have problems related to getting services or payment for services that you believe are covered for you. See Section 11 for information about making a complaint.

Can your benefits change during the year?

The Medicare program has rules about when and how we can make changes in your benefits. **We can *increase* your benefits at any time during the calendar year** (the current calendar year is the period from January 1 through December 31, 2005). Here are some examples:

- If we decide to add a new benefit, this would be an increase in your benefits (even though you might have to pay something if you use the new benefit).
- If we decide to provide more of some benefit that you already have, this would be an increase in your benefits.
- If we decide to reduce the amount of a copayment, coinsurance, or plan premium, this would also be an increase in your benefits because you would be getting the same benefits for less money.

If we decide to increase any of your benefits during the calendar year, we will let you know in writing.

The Medicare program does not allow us to *decrease* your benefits during the calendar year. We are allowed to decrease your benefits only on January 1, at the beginning of the next calendar year. The Medicare program must approve any *decreases* we make in your benefits. We will tell you in advance (in October 2005) if there are going to be any increases or decreases in your benefits for the next calendar year that begins on January 1, 2006.

At any time during the year, the Medicare program can change its national coverage. Since we cover what Original Medicare covers, we would have to make any change that the Medicare program makes. These changes could be to increase or decrease your benefits, depending on what change the Medicare program makes. In some cases, if your benefits increase, Original Medicare will pay for the benefit for the rest of the calendar year. In those cases, you will have to pay Original Medicare out-of-pocket amounts for those services. We will let you know in advance if you will have to pay Original Medicare out-of-pocket amounts for an increased benefit.

Can the prescription drugs that we cover change during the year?

The Medicare program allows us to make changes in our prescription drug formulary list at any time during the calendar year. As we explain in Section 7, the formulary is a list of drugs. A change in our drug formulary list could affect which drugs are covered for you. Note that the formulary list applies only to the covered services listed in the Benefits Chart under the heading that says, "WHA *Care+* Prescription Drug Benefit (outpatient prescription drugs)."

Section 6 Medical care and services that are **NOT** covered (list of exclusions and limitations)

Introduction

The purpose of this section is to tell you about medical care and services that are not covered ("excluded") or are limited by WHA *Care*+. The list below tells about these exclusions and limitations. The list describes services that are not covered under *any* conditions, and some services that are covered only under specific conditions. (The Benefits Chart in Section 5 also explains about some restrictions or limitations that apply to certain services).

If you get services that are not covered, you must pay for them yourself

We will not pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will Original Medicare, unless they are found upon appeal to be services that we should have paid or covered (appeals are discussed in Sections 11 and 12).

What services are not covered by WHA Care+*?*

In addition to any exclusions or limitations described in the Benefits Chart in Section 5, or anywhere else in this booklet, **the following items and services are not covered by WHA *Care*+:**

1. Services that are not covered under Original Medicare, *unless* such services are specifically listed as covered in Section 5.
2. Services that you get from non-plan providers, *except* for care for a medical emergency and urgently needed care, renal (kidney) dialysis services that you get when you are temporarily outside the plan's service area, and care from non-plan providers that is arranged or approved by a plan provider. See other parts of this booklet (especially Sections 3 and 4) for information about using plan providers and the exceptions that apply.
3. Services that you get without a referral from your PCP, when a referral from your PCP is required for getting that service.
4. Services that you get without prior authorization, when prior authorization is required for getting that service. (Section 5 gives a definition of prior authorization and tells which services require prior authorization.)
5. Services that are not reasonable and necessary under Original Medicare program standards unless otherwise listed as a covered service. As noted in Section 5, we provide all covered services according to Medicare guidelines.

6. Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency. (See Section 4 for more information about getting care for a medical emergency).
7. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under an approved clinical trial. Experimental procedures and items are those items and procedures determined by WHA and Original Medicare to not be generally accepted by the medical community. See Section 8 for information about participation in clinical trials while you are a member of WHA *Care+*.
8. Surgical treatment of morbid obesity *unless* medically necessary and covered under Original Medicare.
9. Private room in a hospital, *unless* medically necessary.
10. Private duty nurses.
11. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
12. Nursing care on a full-time basis in your home.
13. Custodial care is not covered by WHA *Care+ unless* it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. “Custodial care” includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
14. Homemaker services.
15. Charges imposed by immediate relatives or members of your household.
16. Meals delivered to your home.
17. Unless medically necessary, elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance.
18. Cosmetic surgery or procedures, *unless* it is needed because of accidental injury or to improve the function of a malformed part of the body. Breast surgery and all stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast, is covered.
19. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. Certain dental services that you get when you are in the hospital will be covered.
20. Chiropractic care is generally not covered under the plan, (with the exception of manual

manipulation of the spine, as outlined in Section 5) and is limited according to Medicare guidelines.

21. Routine foot care is generally not covered under the plan and is limited according to Medicare guidelines.

22. Orthopedic shoes, *unless* they are part of a leg brace and are included in the cost of the leg brace. There is an exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 5, in the Benefits Chart under “Outpatient Medical Services”).

23. Supportive devices for the feet. *There is an exception*: orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 5, in the Benefits Chart under “Outpatient Medical Services”).

24. Eyeglasses (*except* after cataract surgery), radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.

25. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy or hyporgasmy.

26. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices. (Medically necessary services for infertility are covered according to Original Medicare guidelines.)

27. Acupuncture.

28. Naturopaths' services.

29. Services provided to veterans in Veteran's Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost sharing is more than the cost sharing required under WHA *Care*+, we will reimburse veterans for the difference. Members are still responsible for the WHA *Care*+ cost sharing amount.

Section 7 Prescription drugs (this section gives additional information about the outpatient prescription drug benefit that is listed in the Benefits Chart in Section 5)

Introduction to the WHA *Care+ outpatient prescription drug benefit*

The purpose of this section is to give details about the WHA *Care*+ outpatient prescription drug benefit. This benefit is listed in the Benefits Chart in Section 5 under the heading, "WHA *Care*+ prescription drug benefit (outpatient prescription drugs)." This benefit covers certain drugs that require a prescription and that have been approved by the Food and Drug Administration (FDA).

Western Health Advantage has chosen **Medco Health** to manage your prescription drug benefits. Medco Health's interactive telephone service gives you a convenient way to get information or materials – at any time of the day or night. And with the voice-activated feature, you don't even have to press numbers on the telephone.

Before you call, you should have your WHA member ID number (which is on your WHA *Care*+ ID card) and other numbers you might need, such as your credit card number or your prescription number. Then dial **1-800-903-8664** to reach the **Medco Health Member Services**. To access TTY service for hearing-impaired members call 1-800-759-1089. Most Medco Health's services are available 24 hours a day, seven days a week except Thanksgiving and Christmas.

With few exceptions, your prescriptions must be from plan providers and must be filled at a plan pharmacy or through our mail order service.

In nearly all cases, your prescriptions are covered only if they are written or ordered by a plan doctor or other plan provider. In addition, as we explain later on, you must fill your prescriptions at certain pharmacies or through our own mail order pharmacy service. There is an exception for medical emergencies and urgently needed care. If it is a medical emergency or urgently needed care, we cover prescriptions you get from doctors who are not plan providers and prescriptions that are filled at non-plan pharmacies. Section 4 tells about care for a medical emergency and urgently needed care.

The WHA Care+ formulary list

The WHA *Care*+ formulary list was created by a group of doctors and pharmacists. They picked the drugs that are on this formulary list **based on how safe and effective they are, and how much they cost.** We call the drugs that are on this list "formulary drugs." We call drugs that are *not* on the list "non-formulary drugs." **To get a copy of the formulary list**, call WHA *Care*+ Member Services: 1-888-563-2252, 1-916-563-2252 or (TTY) 1-888-877-5378, calling hours are Monday through Friday, 8:00 a.m. to 5:00 p.m. The formulary list is also available on the WHA *Care*+ web site on the Internet at www.westernhealth.com.

WHA uses a 3 tier open formulary system. Generic medications listed on the formulary are covered at a $10 copayment. Brand name medications listed on the formulary are covered at a $20 copayment. Drugs, which are not listed on the formulary, are covered at a $35 copayment

Generic drugs cost less, but **generic and brand-name drugs are the same in terms of quality and how they work.** The law requires that a generic drug must contain the same amount of the same active drug ingredient as the brand-name drug. However, a generic drug may differ in certain other ways, such as its color or its flavor, the shape of the pill or tablet, and the inactive (non-drug) ingredients it contains.

How much do you pay when you fill a prescription?

The amount you pay when you fill a covered prescription is called your **copayment.** Your copayment can vary, depending on the drug and on whether you get the drug at a plan pharmacy or through our mail order service.

- When you fill a prescription, you pay either the copayment listed above, or you pay the full cost of the prescription – whichever is *lower*.
- **There is a limit on how much of the drug you can get for one copayment.** For most oral medications, such as pills or other drugs that you swallow, the maximum is a 30 day supply (or less than a *30*-day supply for one copayment if your doctor orders less). For medications other than ones you swallow, the maximum depends on the type of medication. The maximum amount per copayment might be a single container, inhaler unit, package, or course of therapy. For example, you would have to pay two copayments if you got two inhalers. If your doctor prescribes an amount of medication that is *smaller* than the maximum allowed for a single copayment, you must still pay the full copayment.
- If you fill the prescription through our mail order service, you can order a 90-day supply for the cost of two copayments.]

Important things to know about the formulary list and how much you pay

Since the formulary list can change during the year, there could be changes in copays

A committee of doctors and pharmacists reviews and updates the WHA *Care*+ formulary list quarterly throughout the year. This means that drugs can be added to or dropped from the formulary list at any time without notice. Drugs can also be changed from one category of drugs to another within the formulary. Changes in the formulary list can affect what you pay for your prescription. You can call Member Services to find out if your drug is on the formulary list or to get a copy of the formulary list.

Filling your prescriptions at a plan pharmacy or through our mail order service

Filling prescriptions at a plan pharmacy

To get a list of the pharmacies you can use, please refer to your WHA *Care*+ Provider Directory. We call the pharmacies on this list our "plan pharmacies" because we have made arrangements with them to handle prescriptions for members of WHA *Care*+.

To use your prescription drug benefit, you must show your WHA *Care*+ ID card at one of our plan pharmacies. If you do not have your ID card with you when you fill the prescription, you will have to pay the *full cost* of the prescription (rather than paying just your copayment). If this happens to you, you can ask us to reimburse you for our share of the cost by filling out a pharmacy claim form and sending it to us. For more information, call WHA *Care*+ Member Services: 1-888-563-2252, 1-916-563-2252, or (TTY) 1-888-877-5378, calling hours are Monday through Friday, 8:00 a.m. to 5:00 p.m.

If you are a new member and need to have an existing prescription refilled, remember that the prescription must be written by plan provider or it will not be covered (even if you fill it at a plan pharmacy). You should consult with your current doctor to see if he or she wants you to continue on the medication, and you must get a new prescription from your current doctor.

Using the WHA *Care*+ mail order pharmacy service

You can use the mail order service to fill prescriptions for what we call "maintenance drugs". These are drugs that you take on a regular basis, for a chronic or long-term medical condition.

Please note in order to take advantage of the benefits of a mail order service, you must use the **Medco Home Delivery Pharmacy Service** (described below). Prescription drugs that you get at any other mail order service are not covered.

When you order prescription drugs by mail, you must order no more than a 90-day supply of the drug.

The **Medco Home Delivery Pharmacy Service** offers you convenience and potential cost savings. With the Home Delivery Service:

- Your medications are dispensed by one of Medco Health's home delivery pharmacies and delivered to your home.

- Medications are shipped by standard delivery at no additional cost to you. (Express shipping is available for an added charge.)
- You can order and track your prescriptions online at www.medcohealth.com or you can telephone in your order to **Medco Health toll-free. 1-800-903-8664**, TTY 1-800-759-1089, 24 hours a day, 7 days a week except Thanksgiving and Christmas.
- Registered pharmacists are available around the clock for consultations.

You can request additional Home Delivery Pharmacy Service **order forms and envelopes** through Medco Health's website, www.medcohealth.com or calling Medco Health Member Services at **1-800-903-8664,** TTY 1-800-759-1089, 24 hours a day, 7 days a week except Thanksgiving and Christmas.

Using the Home Delivery Pharmacy Service for the first time

Requesting a new prescription for home delivery is simple whether you're ordering by mail or fax. Just follow these steps:

BY MAIL:

Step 1: Ask your doctor to write a new prescription for up to a 90-day supply, plus refills (if appropriated) for up to 1 year.

Step 2: Mail the new prescription(s), along with the enclosed "Ordering Medications" form and the appropriate co-payment, to Medco Health in the return envelope.

BY FAX:

Step 1: Ask your doctor to write a new prescription for up to a 90-day supply, plus refills (if appropriate) for up to a 90-day supply, plus refills (if appropriate) for up to 1 year. Give your doctor your WHA member ID number, which is on your WHA *Care*+ member ID card.

Step 2: Ask your doctor to call 1-888-EASYRX1 (1-888-327-9791). Medco Health will give him or her directions for faxing your prescription to Medco Health. You will be billed later.

ONLINE:

You can request new prescriptions online by visiting Medco Health at www.medcohealth.com

Step 1: If you haven't already done so, take a few moments to register with Medco Health, making sure you let us know that you are a Medco Health plan member when prompted. Once you are registered, all you need to do when you return is log in using the e-mail address and password you created.

Step 2: Once you registered and logged in, select the "My Benefits" tab at the top of the page. Then choose the "Order new prescriptions" link and follow the online instructions.

Your medication will be delivered to your home within 7 to 11 days after Medco Health receives your order. Orders placed via the Internet, telephone, or fax may be received even faster. Standard shipping is free.

Since your medication can take 7 to 11 days to be delivered, you should have at least a 14-day supply of that medication on hand to hold you over. If you do not have enough medication, you may need to ask your doctor for another prescription for a 14-day supply that you can fill at your local retail network pharmacy.

Things to know about getting your prescriptions filled

If you fill your prescription at a pharmacy that is not a plan pharmacy, you will have to pay the full cost of the prescription yourself, and we will not pay for any part of the cost. There is an exception: prescriptions filled at a non-plan pharmacy are covered if they are related to care for a medical emergency or urgently needed care. In this situation, you can ask us to pay our share of the cost by filling out a pharmacy claim form and sending it to Medco Health. To get a claim form and more information, call 1-800-903-8664, TTY 1-800-759-1089, 24 hours a day, 7 days a week except Thanksgiving and Christmas.

If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. If you plan to be away for three months or less, you may be able to order your prescription drugs ahead of time through the WHA *Care+* mail order pharmacy, or refill your prescriptions at a plan pharmacy away from home. There is no out-of-service-area benefit for prescription drugs (Section 3 tells you about our service area). Drugs you get from non-plan pharmacies while out of our service area will not be covered, regardless of the circumstances, unless they are part of care for a medical emergency or urgently needed care (care for a medical emergency and urgently needed care are discussed in Section 4).

Prescription drug benefit exclusions (drugs that are not covered)

The following list shows which types of drugs or categories of drugs are **not** covered. These are called "exclusions". Also, see Section 5 ("Benefits chart – a list of the covered services you get as a plan member"), Section 6 ("Medical care and services that are not covered – a list of exclusions"), and the formulary list for more information about drugs that are not covered.

1. Diet Aides, Anorexiants, appetite suppressants and diet aids.

2. Diet Supplements, nutritional replacements and dietary supplements, except as otherwise provided herein.

3. Elective or voluntary enhancement procedures, services, supplies and medications including, but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance, unless medically necessary.

4. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under an approved clinical trial. Experimental procedures and items are those items and procedures determined by WHA *Care*+ and Original Medicare not to be generally accepted by the medical community. When deciding if a service or item is experimental, WHA *Care*+ will follow Medicare's manuals or will follow decisions already made by Medicare.

5. Medications that are experimental or not approved for use by the FDA for the condition or indication are excluded. FDA Approved Drugs are those drugs, medications and biologicals approved by the Food and Drug Administration and listed in the United States Pharmacopoeia, the AMA Drug Evaluations and/or the American Hospital Formulary.

6. Medications that are investigational are excluded, except for those medications approved by the FDA as Treatment Investigational New Drugs or classified as Group "C" cancer drugs by the National Cancer Institute (NCI) to be used only for the purposes approved by the FDA or the NCI, when *prior authorized* by WHA *Care+.*

7. Nicotine gum, nicotine nasal spray and nicotine patches are excluded.

8. Obesity and treatment for obesity, except under specific conditions as covered by Medicare. Examples include, but are not limited to: drugs, weight reduction programs and related supplies, and liposuction.

9. Over-the-counter medications or medications that do not require a prescription are excluded (except for insulin and insulin syringes with needles for diabetics, and other supplies and equipment for the treatment of diabetes).

10. Prescriptions written by dentists.

11. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy or hyporgasmy.

12. Vitamins, except generics included in the formulary.

How to get help with questions or problems related to your prescription drug coverage

Western Health Advantage has chosen **Medco Health** to manage your prescription drug benefits. Medco Health's interactive telephone service gives you a convenient way to get information or materials – at any time of the day or night. And with the voice-activated feature, you don't even have to press numbers on the telephone.

If you have any problems or concerns related to using your prescription drug coverage, please call **Medco Health Member Services**. Before you call, you should have your WHA member ID number (which is on your WHA *Care*+ ID card) and other numbers you might need, such as your credit card number or your prescription number. Then dial **1-800-903-8664**. To access TTY service for hearing-impaired members call 1-800-948-8779, 24 hours a day, 7 days a week except Thanksgiving and Christmas.

From time to time, WHA *Care*+ may make decisions that affect your prescription drug coverage, such as whether a particular drug is covered for you. If you are unhappy about a decision we make about whether a prescription is covered, or the amount of payment for a prescription, you have the right to make an appeal (an appeal asks us to reconsider and change our decision about coverage or payment). If you want to make any *other* types of complaints related to your prescription drug benefit, you would file a "grievance." Section 11 discusses grievances and appeals. You can also call Member Services to get additional information or help with a grievance or appeal.

Medicare-Approved Discount Drug Card Program

WHA offers a Discount Drug Card Program with the Medicare-approved seal for people with Medicare. This means Medicare has approved our drug discount card program. While Medicare has approved our drug discount card, it is separate from the Medicare program and is not intended to replace any prescription drug benefits that you get with WHA *Care*+.

This program is designed to help you lower the costs of your prescription drugs. As a member of the program you will be able to receive discount prices when you use your membership card at a plan pharmacy. You may also qualify for additional assistance up to $600 from Medicare this year and again next year to be used toward the cost of your prescription drugs from plan pharmacies. This assistance is in addition to the discounts you would get through our discount drug card program.

To qualify for additional assistance up to $600 from Medicare you will need to complete an additional form. The additional form will ask questions about your current healthcare coverage and your income level.

You can get more information on this program from Member Services (call the number in Section 1 of this booklet to contact Member Services).

SECTION 8 Hospital care, skilled nursing facility care, and other services (this section gives additional information about some of the covered services that are listed in the Benefits Chart in Section 5)

Hospital care

If you need hospital care, we will arrange covered services for you. Covered services are listed in the Benefits Chart in Section 5 under the heading "Inpatient Hospital Care." We use "hospital" to mean a facility that is certified by the Medicare program and licensed by the state to provide inpatient, outpatient, diagnostic, and therapeutic services. The term "hospital" does not include facilities that mainly provide custodial care (such as convalescent nursing homes or rest homes). By "custodial care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.

What is a "benefit period" for hospital care?

WHA *Care*+ uses benefit periods to determine your coverage for inpatient services during a hospital stay (generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital). A "**benefit period**" begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility (SNF). The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. (Later in this section we explain about skilled nursing facility services).

Please note that after your hospital day limits are used up, we will still pay for covered physician services and other medical services. These services are listed in the Benefits Chart in Section 5 under the heading, "Inpatient services (when the hospital or SNF days are not or are no longer covered)".

As shown in the Benefits Chart in Section 5, you must pay the inpatient hospital copayment for each benefit period.

What happens if you join or drop out of WHA *Care*+ during a hospital stay?

If you either join or leave WHA *Care*+ during an inpatient hospital stay, special rules apply to your coverage for the stay and to what you owe for this stay. If this situation applies to you, please call Member Services at the telephone number displayed in Section 1 of this booklet. Member Services can explain how your services are covered for this stay, and what you owe to WHA *Care*+, if any, for the periods of your stay when you were and were not a plan member.

Skilled nursing facility care (SNF care)

If you need skilled nursing facility care, we will arrange these services for you. Covered services are listed in the Benefits Chart in Section 5 under the heading "Skilled nursing facility care." The purpose of this subsection is to tell you more about some rules that apply to your covered services.

A skilled nursing facility is **a place that provides skilled nursing or skilled rehabilitation services.** It can be a separate facility, or part of a hospital or other health care facility. A **s**killed **n**ursing **f**acility is called a "SNF" for short. The term "skilled nursing facility" does not include places that mainly provide custodial care, such as convalescent nursing homes or rest homes. (By "custodial care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.)

There is no copayment for services in a Skilled Nursing Facility.

You are covered for 100 days each benefit period.

No prior Hospital Stay is required.

What is skilled nursing facility care?

"Skilled nursing facility care" means a level of care ordered by a physician that must be given or supervised by licensed health care professionals. It can be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services include physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment such as how to use a walker or get in and out of a wheel chair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to do usual daily activities such as eating and dressing by yourself.

To be covered, the care you get in a SNF must meet certain requirements.

To be covered, you must need daily skilled nursing or skilled rehabilitation care, or both. If you do not need daily skilled care, other arrangements for care would need to be made. Note that medical services and other skilled care will still be covered when you start needing less than daily skilled care in the SNF.

Stays that provide custodial care only are not covered

"Custodial care" is care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who do not have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by WHA *Care*+ unless it is provided as other care you are getting *in addition to* daily skilled nursing care and/or skilled rehabilitation services.

There are benefit period limitations on coverage of skilled nursing facility care

Inpatient skilled nursing facility coverage is limited to 100 days each benefit period. A "**benefit period**" begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

Please note that after your SNF day limits are used up, physician services and other medical services will still be covered. These services are listed in the Benefits Chart in Section 5 under the heading, "Inpatient services (when the hospital or SNF days are not or are no longer covered)".

In some situations, you may be able to get care in a SNF that is not a plan provider

Generally, you will get your skilled nursing facility care from SNFs that are plan providers for WHA *Care*+. However, *if certain conditions are met*, you may be able to get your skilled nursing facility care from a SNF that is not a plan provider. One of the conditions is that the SNF that is not a plan provider must be willing to accept WHA's rates for payment. At your request, we may be able to arrange for you to get your skilled nursing facility care from one of the facilities listed below (in these situations, the facility is called a "Home SNF"):

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as the place gives skilled nursing facility care).
- A SNF where your spouse is living at the time you leave the hospital.

What happens if you join or drop out of WHA *Care*+ during a SNF stay?

If you either join or leave WHA *Care*+ during a SNF stay, special rules apply to your coverage for the stay and to what you owe for this stay. If this situation applies to you, please call Member Services at the telephone number displayed in Section 1 of this booklet. Member Services can explain how your services are covered for this stay, and what you owe to WHA, if any, for the periods of your stay when you were and were not a plan member.

Home health agency care

Home health care is skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Section 5 under the heading "Home health care." If you need home health care services, we will arrange these services for you if the requirements described below are met.

What are the requirements for getting home health agency services?

To get home health agency care benefits, you must meet all of these conditions:

1. You must be **home-bound**. This means that you are normally unable to leave your home and that leaving home is a major effort. When you leave home, it must be to get medical treatment or be infrequent, for a short time. You may attend religious services. You can also get care in an adult day care program that is licensed or certified by a state or accredited to furnish adult day care services in a state.

   Occasional absences from the home for non-medical purposes, such as an occasional trip to the barber or a walk around the block or a drive, would not mean that you are not homebound if the absences are on infrequent or are of relatively short duration. The absences cannot indicate that you have the capacity to obtain the health care provided outside of your home.

   Generally speaking, you will be considered to be homebound if you have a condition due to an illness or injury that restricts your ability to leave your home except with the aid of supportive devices or if leaving home is medically contraindicated. "Supportive devices" include crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person.
2. Your doctor must decide that you need medical care in your home, and must make a plan for your care at home. Your **plan of care** describes the services you need, how often you need them, and what type of health care worker should give you these services.
3. The home health agency caring for you must be approved by the Medicare program.
4. **You must need *at least one* of the following types of skilled care:**
   - Skilled nursing care on an "intermittent" (not full time) basis. Generally, this means that you must need at least one skilled nursing visit every 60 days and not require daily skilled nursing care for more than 21 days. Skilled nursing care includes services that can only be performed by or under the supervision of a licensed nurse.
   - Physical therapy, which includes exercise to regain movement and strength to an area of the body, and training on how to use special equipment or do daily activities such as how to use a walker or get in and out of a wheel chair or bathtub.
   - Speech therapy, which includes exercise to regain and strengthen speech skills or to treat a swallowing problem.
   - Continuing occupational therapy, which helps you learn how to do usual daily activities by yourself. For example, you might learn new ways to eat or new ways to get dressed.

If you meet all four of these conditions for getting home health care, WHA *Care+* covers either part-time or intermittent home health care services. As explained below, this means that there are limits on the number of hours per day and days per week that you can get home health services.

Home health care can include services from a home health aide, as long as you are also getting skilled care

As long as some qualifying skilled services are *also* included, the home health care you get can include services from a home health aide. A home health aide does not have a nursing license. The home health aide provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care such as bathing, using the toilet, dressing, or carrying out the prescribed exercises. The services from a home health aide must be part of the home care of your illness or injury, and they are not covered unless you are *also* getting a covered skilled service. Home health services do not include the costs of housekeepers, food service arrangements, or full-time nursing care at home.

What are "part time" and "intermittent" home health care services?

If you meet the requirements given above for getting covered home health services, you may be eligible for "part time" or "intermittent" skilled nursing services and home health aide services:

- "**Part-time**" or "**Intermittent"** means your skilled nursing and home health aide services combined total less than 8 hours per day and 35 or fewer hours each week.

Hospice care for people who are terminally ill

"Hospice" is a special way of caring for people who are terminally ill, and for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients make the most of the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

As a member of WHA *Care*+, you may receive care from any Medicare-certified hospice. Your doctor can help you arrange for your care in a hospice. If you are interested in using hospice services, you can call Member Services at the number displayed in Section 1 of this booklet to get a list of the Medicare-certified hospice providers in your area, or you can call the Regional Home Health Intermediary at Blue Cross of CA – Medicare 1-877-602-7904 or (TTY) 866-879-0235, Monday through Thursday 8:30 a.m. to 4 p.m. (If you are enrolled in Medicare Part B only and not entitled to Part A, you should call Member Services to get information on your hospice coverage.)

If you enroll in a Medicare-certified hospice, Original Medicare (rather than WHA *Care*+) pays the hospice for the hospice services you receive. Your hospice doctor can be a plan provider or a non-plan provider. If you choose to enroll in a Medicare-certified hospice, you are still a plan member and continue to get the rest of your care that is unrelated to your terminal condition through WHA *Care*+. If you use non-plan providers for your routine care, Original Medicare (rather than WHA *Care*+) will cover your care and you will have to pay Original Medicare out-of-pocket amounts.

The Medicare program has written a booklet about "Medicare Hospice Benefits." To get a free copy, call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), 24 hours a day, 7 days a

week, which is the national Medicare help line, or visit the Medicare website at www.medicare.gov. Section 1 tells more about how to contact the Medicare program and about the website.

Organ transplants

If you need an organ transplant, we will arrange to have your case reviewed by one of the transplant centers that is approved by Medicare (some hospitals that perform transplants are approved by Medicare, and others are not). The Medicare-approved transplant center will decide whether you are a candidate for a transplant. When all requirements are met, the following types of transplants are covered: corneal, kidney, pancreas (when performed with or after a Medicare-covered kidney transplant), liver, heart, lung, heart-lung, bone marrow, intestinal/multivisceral, and stem cell. Please be aware that the following transplants are covered only if they are performed in a Medicare-approved transplant center: heart, liver, lung, heart-lung, and intestinal/multivisceral transplants.

Participating in a clinical trial

A "clinical trial" is a way of testing new types of medical care, like how well a new cancer drug works. Clinical trials are one of the final stages of a research process to find better ways to prevent, diagnose, or treat diseases. The trials help doctors and researchers see if a new approach works and if it is safe.

There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, Original Medicare (and not WHA *Care+*) pays the clinical trial doctors and other providers for the covered services you receive that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in WHA *Care+* and continue to get the rest of your care that is unrelated to the clinical trial through WHA *Care+.* You will have to pay the Original Medicare coinsurance for the clinical trial services.

The Medicare program has written a booklet about "Medicare and Clinical Trials." To get a free copy, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, or visit www.medicare.gov on the web. Section 1 tells more about how to contact the Medicare program and about Medicare's website.

You do *not* need to get a referral from a plan provider to join a clinical trial, and the clinical trial providers do *not* need to be plan providers. However, please be sure to **tell us before you start a clinical trial** so that we can keep track of your health care services. When you tell us about starting a clinical trial, we can let you know what services you will get from clinical trial providers and what coinsurance and copayments you will have to pay. If you participate in a clinical trial, you may stay enrolled in WHA *Care+* and continue to get the rest of your care that is unrelated to the clinical trial through WHA *Care+.*

Care in Religious Non-Medical Health Care Institutions

Care in a Medicare-certified Religious Non-medical Health Care Institution (RNHCI) is covered by WHA *Care*+ under certain conditions. Covered services in a RNHCI are limited to non-religious aspects of care. To be eligible for covered services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital care or extended care services, or care in a home health agency. You may get services when furnished in the home, but only items and services ordinarily furnished by home health agencies that are not RNHCIs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "nonexcepted" medical treatment. ("Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under Federal, State or local law. "Nonexcepted" medical treatment is any other medical care or treatment.) You must also get authorization (approval) in advance from WHA *Care*+, or your stay in the RNHCI may not be covered.

SECTION 9 What you must pay for the care you receive

Paying the premium for Medicare Part B for your coverage as a member of WHA Care+

To be a member of WHA *Care+*, you must continue to pay your Medicare Part B premium. If you have to pay a Medicare Part A premium (most people do not), you must continue paying that premium to be a member.

Paying your share of the cost when you get covered services

What are "copayments"?

- A **"copayment"** is a payment you make for your share of the cost of certain covered services you receive. A copayment is **a set amount per service** (such as paying $10 for a doctor visit). You pay it when you get the service. The Benefits Chart in Section 5 gives your copayments for covered services. Section 7 gives your copayments for prescription drugs.

You must pay the full cost of services that are not covered

You are personally responsible to pay for care and services that are not covered by WHA *Care+*. Other sections of this booklet tell about covered services and the rules that apply to getting your care as a plan member. With few exceptions, you must pay for services you receive from providers who are not part of WHA *Care+* unless WHA has approved these services in advance. The exceptions are care for a medical emergency, urgently needed care, out-of-area renal (kidney) dialysis services, and services that are found upon appeal to be services that we should have paid or covered. (Sections 2 and 4 explain about using plan providers and the exceptions that apply.)

Please keep us up-to-date on any other health insurance coverage you have

Using *all* of your insurance coverage

If you have other health insurance coverage besides WHA *Care+*, it is important to use this other coverage *in combination with* your coverage as a member to pay for the care you receive. This is

called “coordination of benefits” because it involves *coordinating* all of the health *benefits* that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

Let us know if you have additional insurance

You must tell us if you have any other health insurance coverage besides WHA *Care*+, and let us know whenever there are any *changes* in your additional insurance coverage. The types of additional insurance you might have include the following:

- Coverage that you have from an employer’s group health insurance for *employees* or *retirees*, either through yourself or your spouse.
- Coverage that you have under workers’ compensation because of a job-related illness or injury, or under the Federal Black Lung Program.
- Coverage you have for an accident where no-fault insurance or liability insurance is involved.
- Coverage you have through Medi-Cal.
- Coverage you have through the “Tricare for Life” program (veteran’s benefits).
- Coverage you have for dental insurance or prescription drugs.
- “Continuation coverage” that you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions).

Who pays first when you have additional insurance?

When you have additional insurance coverage, how we coordinate your benefits as a member of WHA *Care*+ with your benefits from other insurance depends on your situation. With coordination of benefits, you will often get your care as usual through WHA *Care*+, and the other insurance you have will simply help pay for the care you receive. In other situations, such as for benefits that are not covered by WHA *Care*+, you may get your care outside of WHA *Care+.*

In general, the insurance company that pays its share of your bills *first* is called the “**primary payer**.” Then the other company or companies that are involved -- called the “**secondary payers**” -- each pay their share of what is left of your bills. Often your other insurance company will settle its share of payment directly with us and you will not have to be involved. However, if payment owed to us is sent directly to you, you are required under Medicare law to give this payment to us. When you have additional health insurance, **whether we pay first or second --or at all-- depends on what type or types of additional insurance you have and the rules that apply to your situation**. Many of these rules are set by Medicare. Some of them take into account whether you have a disability or have End-Stage Renal Disease (permanent kidney failure), or how many employees are covered by an employer’s group insurance.

If you have additional health insurance, please call Member Services at the phone number

displayed in Section 1 of this booklet to find out which rules apply to your situation, and how payment will be handled. Also, the Medicare program has written a booklet with general information about what happens when people with Medicare have additional insurance. It's called *Medicare and Other Health Benefits: Your Guide to Who Pays First.* You can get a copy by calling 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), 24 hours a day, 7 days a week, or by visiting the www.medicare.gov website.

What should you do if you have bills from non-plan providers that you think we should pay?

As explained in Sections 3 and 4, we cover certain health care services that you get from non-plan providers. These include care for a medical emergency, urgently needed care, renal dialysis that you get when you are outside the plan's service area, care that has been approved in advance by WHA *Care+,* and services that we denied but that were overturned in an appeal. If a non-plan provider asks you to pay for covered services you get in these situations, please contact us at:

WHA *Care+*,
1331 Garden Highway, Suite 100,
Sacramento, CA 95835

or call 1-916-563-2252, 1-888-563-2252 or TTY 1-888-877-5378,
Monday through Friday, 8:00 a.m. to 5:00 p.m.

It is best to ask a non-plan provider to bill us first, but if you have already paid for the covered services we will reimburse you for our share of the cost. If you received a bill for the services, you can send the bill to us for payment. We will pay your doctor for our share of the bill and will let you know what, if anything, you must pay. You will not have to pay a non-plan provider any more than what he or she would have received from you if you had been covered with Original Medicare.

Section 10 Your rights and responsibilities as a member of WHA *Care+*

Introduction about your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this first part of Section 10, we explain your Medicare rights and protections as a member of WHA *Care+*. Then, after we have explained your rights, we tell you what you can do if you think you are being treated unfairly or your rights are not being respected. If you want to receive Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), 24 hours a day, 7 days a week.

Your right to be treated with fairness and respect

You have the right to be treated with dignity, respect, and fairness at all times. WHA must obey laws against discrimination that protect you from unfair treatment. These laws say that we cannot discriminate against you (treat you unfairly) because of your race or color, age, religion, national origin, or any mental or physical disability you may have. If you need help with communication, such as help from a language interpreter, please call Member Services at the number displayed in Section 1 of this booklet. Member Services can also help if you need to file a complaint about access (such as wheel chair access).

Your right to the privacy of your medical records and personal health information

There are federal and state laws that protect the privacy of your medical records and personal health information. We keep your personal health information private as protected under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people do not see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for

you) before we can give your health information to anyone who is not providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at your medical records, and to get a copy of the records (there may be a fee charged for making copies). You also have the right to ask plan providers to make additions or corrections to your medical records (if you ask plan providers to do this, they will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Member Services at the phone number displayed in Section 1 of this booklet.

Your right to see plan providers and get covered services within a reasonable period of time

As explained in this booklet, you will get most or all of your care from plan providers, that is, from doctors and other health providers who are part of WHA *Care*+. You have the right to choose a plan provider (we will tell you which doctors are accepting new patients). You have the right to go to a women's health specialist (such as a gynecologist) without a referral. You have the right to timely access to your providers and to see specialists when care from a specialist is needed. "Timely access" means that you can get appointments and services within a reasonable amount of time. Section 3 explains how to use plan providers to get the care and services you need. Section 4 explains your rights to get care for a medical emergency and urgently needed care.

Your right to know your treatment choices and participate in decisions about your health care

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment choices that are recommended for your condition, no matter what they cost or whether they are covered by WHA *Care*+. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a plan provider has denied care that you believe you are entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision. "Initial decisions" are discussed in Section 12.

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone you trust the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called "**advance directives.**" There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you decide that you want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as HICAP. Section 1 of this booklet tells how to contact HICAP. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have *not* signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is *your choice* whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you *have* signed an advance directive, and you believe that a doctor or hospital has not followed the instructions in it, you may file a complaint with the Department of Managed Health Care (DMHC). The DMHC has a toll-free telephone number 1-888-HMO-2219, TDD 1-877-688-9891.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "grievances" are the two different types of complaints you can make. Which one you make depends on your situation. Appeals are discussed in Sections 11 and 12, and grievances are discussed in Section 11.

If you make a complaint, we must treat you fairly (i.e., not discriminate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed *against* WHA in the past. To get this information, call Member Services at the phone number displayed in Section 1 of this booklet.

Your right to get information about your health care coverage and costs

This booklet tells you what medical services are covered for you as a plan member and what you have to pay. If you need more information, please call Member Services at the number displayed in Section 1 of this booklet. You have the right to an explanation from us about any bills you may get for services not covered by WHA *Care+.* We must tell you in writing why we will not pay for or allow you to get a service, and how you can file an appeal to ask us to change this decision. See Sections 11 and 12 for more information about filing an appeal.

Your right to get information about Western Health Advantage, WHA Care+*, and plan providers*

You have the right to get information from us about WHA and WHA *Care+*. This includes information about our financial condition, about our health care providers and their qualifications, and about how WHA *Care+* compares to other health plans. You have the right to find out from us how we pay our doctors. To get any of this information, call Member Services at the phone number displayed in Section 1 of this booklet.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call Member Services at the number displayed in Section 1 of this booklet. You can also get free help and information from HICAP (Section 1 tells how to contact HICAP). In addition, the Medicare program has written a booklet called *Your Medicare Rights and Protections.* To get a free copy, call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), 24 hours a day, 7 days a week. Or you can visit the Medicare website at www.medicare.gov to order this booklet or print it directly from your computer.

What can you do if you think you have been treated unfairly or your rights are not being respected?

If you think you have been treated unfairly or your rights have not been respected, what you should do depends on your situation.

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, please let us know. Or, you can call the Western Regional Office for Civil Rights in your area at (213) 894-3437, 300 North Los Angeles Street, Suite 2010, Los Angeles, CA 90012.
- For any other kind of concern or problem related to your Medicare rights and protections described in this section, you can call Member Services at the number displayed in Section 1 of this booklet. You can also get help from HICAP (Section 1 tells how to contact HICAP in your state).

What are your responsibilities as a member of WHA Care+*?*

Along with the rights you have as a member of WHA *Care*+, you also have some responsibilities. Your responsibilities include the following:

- To get familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet and other information we give you to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Member Services at the phone number displayed in Section 1 of this booklet if you have any questions.
- To give your doctor and other providers the information they need to care for you, and to follow the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions.
- To act in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals, and other offices.
- To pay your plan premiums and any copayments you may owe for the covered services you get. You must also meet your other financial responsibilities that are described in Section 9 of this booklet.
- To let us know if you have any questions, concerns, problems, or suggestions. If you do, please call Member Services at the phone number displayed in Section 1 of this booklet.

SECTION 11 Appeals and grievances: what to do if you have complaints

Introduction

We encourage you to let us know right away if you have questions, concerns, or problems related to your covered services or the care you receive. Please call Member Services at the number displayed in Section 1 of this booklet.

This section gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your medical care as a plan member. The Medicare program has helped set the rules about what you need to do to make a complaint, and what we are required to do when we receive a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from WHA *Care+* or penalized in any way if you make a complaint.

What are appeals and grievances?

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "grievances" are the two different types of complaints you can make.

- An "**appeal**" is the type of complaint you make **when you want us to reconsider and change a decision we have made about what services are covered for you or what we will pay for a service.** For example, if we refuse to cover or pay for services you think we should cover, you can file an appeal. If WHA or one of our plan providers refuses to give you a service you think should be covered, you can file an appeal. If WHA or one of our plan providers reduces or cuts back on services you have been receiving, you can file an appeal. If you think we are stopping your coverage of a service too soon, you can file an appeal.

- **A "grievance"** is the type of complaint you make **if you have any other type of problem with WHA *Care+* or one of our plan providers.** For example, you would file a grievance if you have a problem with things such as the quality of your care, waiting times

for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor's office.

This section tells how to make complaints in different situations

The rest of this section has separate parts that tell you how to make a complaint in each of the following situations:

1. **Making complaints (called "appeals") about what we will cover for you or what we will pay for.** If WHA or your doctor or another plan provider has refused to give you a service you think is covered, you can make an appeal. If we have refused to pay for a service you think is covered for you, you can make an appeal. If you have been receiving a covered service, and you think that service is being reduced or ending too soon, you can make an appeal. When you file an appeal, you are asking us to reconsider and change a decision we have made about what services we will cover for you (which includes whether we will pay for your care or how much we will pay).

2. **Making complaints (called "appeals") if you think you are being discharged from the hospital too soon**. There is a special type of appeal that applies only to hospital discharges. If you think our coverage of your hospital stay is ending too soon, you can appeal directly and immediately to Lumetra, which is the Quality Improvement Organization (QIO) in the State of California. Lumetra is a group of health professionals in California that is paid to handle this type of appeal from Medicare patients. If you make this type of appeal, your stay may be covered during the time period the QIO uses to make its determination. You must act very quickly to make this type of appeal, and it will be decided quickly.

3. **Making complaints (called "appeals") if you think your coverage for SNF, home health or comprehensive outpatient rehabilitation facility services is ending too soon.** There is another special type of appeal that applies only to when coverage will end for SNF, home health or comprehensive outpatient rehabilitation facility services. If you think your coverage is ending too soon, you can appeal directly and immediately to Lumetra, which is the Quality Improvement Organization (QIO) in the State of California. If you make this type of appeal, your stay may be covered during the time period the QIO uses to make its determination. You must act very quickly to make this type of appeal, and it will be decided quickly.

4. **Making complaints (called "grievances") about any other type of problem you have with WHA *Care*+ or one of our plan providers**. If you want to make a complaint about any type of problem other than the two that are listed above, a grievance is the type of complaint you would make. For example, you would file a grievance to complain about problems with the quality or timeliness of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor's office. Generally, you would file the grievance with WHA. But for many problems related to quality of care you get from plan providers, you can also complain to Lumetra, which is the Quality Improvement Organization (QIO) in the State of California.

PART 1. Making complaints (called "appeals") to WHA to change a decision about what we will cover for you or what we will pay for

This part of Section 11 explains what you can do if you have problems getting the medical care you believe we should provide. We use the word "provide" in a general way to include such things as authorizing care, paying for care, arranging for someone to provide care, or continuing to provide a medical treatment you have been getting. Problems getting the medical care you believe we should provide include the following situations:

- If you are not getting the care you want, and you believe that this care is covered by WHA *Care+.*
- If we will not authorize the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by WHA *Care+*.
- If you are being told that coverage for a treatment or service you have been getting will be reduced or stopped, and you feel that this could harm your health.
- If you have received care that you believe was covered by WHA *Care+* while you were a member, but we have refused to pay for this care.

Six possible steps for requesting care or payment from WHA *Care+*

If you are having a problem getting care or payment for care, there are six possible steps you can take to ask for the care or payment you want from us. At each step, your request is considered and a decision is made. If you are unhappy with the decision, there may be another step you can take if you want to continue requesting the care or payment.

- In Steps 1 and 2, you make your request directly to us. We review it and give you our decision.
- In Steps 3 through 6, people in organizations that are not connected to us make the decisions about your request. To keep the review independent and impartial, those who review the request and make the decision in Steps 3 through 6 are part of (or in some way connected to) the Medicare program, the Social Security Administration, or the federal court system.

The six possible steps are summarized below (they are covered in more detail in Section 12).

STEP 1: The initial decision by WHA

The starting point is when we make an "initial decision" (also called an "organization determination") about your medical care or about paying for care you have already received. When we make an "initial decision," we are giving our interpretation of how the benefits and services that are covered for members of WHA *Care+* apply to your specific situation. As explained in Section 12, you can ask for a "fast initial decision" if you have a request for medical care that needs to be decided more quickly than the standard time frame.

STEP 2: Appealing the initial decision by WHA

If you disagree with the decision we make in Step 1, you may ask us to reconsider our decision. This is called an "**appeal**" or a "request for reconsideration." As explained in Section 12, you can ask for a "fast appeal" if your request is for medical care and it needs to be decided more quickly than the standard time frame. After reviewing your appeal, we will decide whether to stay with our original decision, or change this decision and give you some or all of the care or payment you want.

STEP 3: Review of your request by an Independent Review Organization

If we turn down part or all of your request in Step 2, we are **required** to send your request to an independent review organization that has a contract with the federal government and is not part of WHA. This organization will review your request and make a decision about whether we must give you the care or payment you want.

STEP 4: Review by an Administrative Law Judge

If you are unhappy with the decision made by the organization that reviews your case in Step 3, you may ask for an **Administrative Law Judge** to consider your case and make a decision. The Administrative Law Judge works for the federal government. The dollar value of your medical care must be at least $100 to be considered in Step 4.

STEP 5: Review by a Medicare Appeals Council

If you or we are unhappy with the decision made in Step 4, either of us may be able to ask a **Medicare Appeals Council** to review your case**.** This Council is part of the federal department that runs the Medicare program.

STEP 6: Federal Court

If you or we are unhappy with the decision made by the Medicare Appeals Council in Step 5, either of us may be able to take your case to a Federal Court. The dollar value of your contested medical care must be at least $1,050 to go to a Federal Court.

For a more detailed explanation of all six steps outlined above, see Section 12.

PART 2. Making complaints if you think you are being discharged from the hospital too soon

When you are hospitalized, you have the right to get all the hospital care covered by WHA *Care+* that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your "discharge date") is based on when your stay in the hospital is no longer medically necessary. This part of Section 11 explains what to do if you believe that you are being discharged too soon.

Information you should receive during your hospital stay

When you are admitted to the hospital, someone at the hospital should give you a notice called the *Important Message from Medicare*. This notice explains:

- Your right to get all medically necessary hospital services covered.
- Your right to know about any decisions that the hospital, your doctor, or anyone else makes about your hospital stay and who will pay for it.
- That your doctor or the hospital may arrange for services you will need after you leave the hospital.
- Your right to appeal a discharge decision.

Review of your hospital discharge by the Quality Improvement Organization

If you think that you are being discharged too soon, you must ask your health plan to give you a notice called the *Notice of Discharge & Medicare Appeal Rights.* This notice will tell you:

- Why you are being discharged.
- The date that we will stop covering your hospital stay (stop paying our share of your hospital costs).
- What you can do if you think you are being discharged too soon.
- Who to contact for help.

You (or someone you authorize) may be asked to sign and date this document, to show that you received the notice. Signing the notice does not mean that you agree that you are ready to leave the hospital – it only means that you received the notice. If you do not get the notice after you have said that you think you are being discharged too soon, be sure to ask for it immediately.

You have the right by law to ask for a review of your discharge date. As explained in the *Notice of Discharge & Medicare Appeal Rights*, if you act quickly, you can ask an outside agency called the Quality Improvement Organization to review whether your discharge is medically appropriate.

What is the "Quality Improvement Organization"?

"QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of WHA or your hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. In California, the QIO is called "Lumetra". The doctors and other health experts in Lumetra review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital stay is ending too soon. Section 1 tells how to contact the QIO.

Getting a QIO review of your hospital discharge

If you want to have your discharge reviewed, you must act quickly to contact the QIO. The *Notice of Discharge & Medicare Appeal Rights* gives the name and telephone number of the QIO and tells you what you must do.

- You must ask the QIO for a **"fast review"** of whether you are ready to leave the hospital. This "fast review" is also called a "fast appeal" because you are appealing the discharge

date that has been set for you.

- You must be sure that you have made your request to the QIO **no later than noon** on the first working day after you are given written notice that you are being discharged from the hospital. This deadline is very important. If you meet this deadline, you are allowed to stay in the hospital past your discharge date without paying for it yourself, while you wait to get the decision from the QIO (see below).

If the QIO reviews your discharge, it will first look at your medical information. Then it will give an opinion about whether it is medically appropriate for you to be discharged on the date that has been set for you. The QIO will make this decision within one full working day after it has received your request and all of the medical information it needs to make a decision.

- If the QIO decides that your discharge date was medically appropriate, you will not be responsible for paying the hospital charges until noon of the calendar day after the QIO gives you its decision.
- If the QIO agrees with you, then we will continue to cover your hospital stay for as long as medically necessary.

What if you do not ask the QIO for a review by the deadline?

You still have another option: asking* WHA *for a "fast appeal" of your discharge

If you do not ask the QIO for a "fast review" ("fast appeal") of your discharge by the deadline, you can ask us for a "fast appeal" of your discharge. How to ask us for a fast appeal is covered briefly in the first part of this section and in more detail in Section 11.

If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you run the risk of having to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care for as long as medically necessary.
- If we decide that you should not have stayed in the hospital beyond your discharge date, then we will **not** cover any hospital care you received if you stayed in the hospital after the discharge date.

You may have to pay if you stay past your discharge date

If you stay in the hospital after your discharge date and do not ask the QIO for immediate review, you may be financially responsible for the cost of many of the services you receive. However, you can appeal any bills for hospital care you receive, using Step 1 of the appeals process described in Section 12.

PART 3. Making complaints if you think your coverage for SNF, home health or comprehensive outpatient rehabilitation facility services is ending too soon.

When you are a patient in a SNF, home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF), you have the right to get all the SNF, HHA or CORF care covered by WHA *Care*+ that is necessary to diagnose and treat your illness or injury. The day we end your SNF, HHA or CORF coverage is based on when your stay is no longer medically necessary. This part of Section 11 explains what to do if you believe that your coverage is ending too soon.

Information you should receive during your SNF, HHA or CORF stay

If we decide to end our coverage for your SNF, HHA or CORF services, you will get written notice either from us or your provider at least 2 calendar days before your coverage ends. You (or someone you authorize) may be asked to sign and date this document to show that you received the notice. Signing the notice does not mean that you agree that coverage should end – it only means that you received the notice.

How to appeal your coverage to the Quality Improvement Organization

You have the right by law to ask for an appeal of our termination of your coverage. As will be explained in the notice you get from us or your provider, you can ask the Quality Improvement Organization (the "QIO") to do an independent review of whether our terminating your coverage is medically appropriate.

How soon do you have to ask the QIO to review your coverage?

If you want to have the termination of your coverage appealed, you must act quickly to contact the QIO. The written notice you got from us or your provider gives the name and telephone number of the QIO and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must be sure to make your request **no later than noon** of the day after you get the notice.
- If you get the notice and you have more than 2 days before your coverage ends, then you must make your request **no later than noon** the day before the date that your Medicare coverage ends.

What will happen during the review?

If the QIO reviews your case, the QIO will ask for your opinion about why you believe the services should continue. You do not have to prepare anything in writing, but you may do so if you wish. the QIO will also look at your medical information, talk to your doctor, and review other information that we have given to the QIO. You and the QIO will each get a copy of our explanation about why your services should not continue.

After reviewing all the information, the QIO will give an opinion about whether it is medically appropriate for your coverage to be terminated on the date that has been set for you. The QIO will make this decision within one full day after it receives the information it needs to make a decision.

What happens if the QIO decides in your favor?

If the QIO agrees with you, then we will continue to cover your SNF, HHA or CORF services for as long as medically necessary.

What happens if the QIO denies your request?

If the QIO decides that our decision to terminate coverage was medically appropriate, you will be responsible for paying the SNF, HHA or CORF charges after the termination date on the advance notice you got from us or your provider. Neither Original Medicare nor WHA will pay for these services. If you stop receiving services on or before the date given on the notice, you can avoid any financial liability.

What if you do not ask the QIO for a review in time?

You still have another option: asking WHA for a "fast appeal" of your discharge

If you do not ask the QIO for a "fast appeal" of your discharge by the deadline, you can ask us for a "fast appeal" of your discharge. How to ask us for a fast appeal is covered briefly in the first part of this section and in more detail in Section 11.

If you ask us for a fast appeal of your termination and you continue getting services from the SNF, HHA, or CORF, you run the risk of having to pay for the care you receive past your termination date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to continue to get your services covered, then we will continue to cover your care for as long as medically necessary.
- If we decide that you should not have continued getting coverage for your care, then we will **not** cover any care you received if you stayed after the termination date.

You may have to pay if you stay past your discharge date

If you do not ask the QIO by noon after the day you are given written notice that we will be terminating coverage for your SNF, HHA or CORF services, and if you stay in the SNF, HHA or CORF after this date, you run the risk of having to pay for the SNF, HHA or CORF care you receive on and after this date. However, you can appeal any bills for SNF, HHA or CORF care you receive using Step 1 of the appeals process described in Section 12.

PART 4. Making complaints (called "grievances") about any other type of problem you have with WHA *Care+ or one of our plan providers*

This last part of Section 11 explains how to make complaints about any *other* type of problem that has not already been discussed earlier in this section. (The problems that have already been discussed are problems related to coverage or payment for care, problems about being discharged from the hospital too soon, and problems about coverage for SNF, HHA, or CORF services ending too soon.)

What is included in "all other types of problems"?

Here are some examples of problems that are included in this category of "all other types of problems":

- Problems with the quality of the medical care you receive, including quality of care during a hospital stay.
- If you feel that you are being encouraged to leave (disenroll from) WHA *Care*+.
- Problems with the customer service you receive.
- Problems with how long you have to spend waiting on the phone, in the waiting room, or in the exam room.
- Problems with getting appointments when you need them, or having to wait a long time for an appointment.
- Disrespectful or rude behavior by doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, or hospitals.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance". In addition, you have the right to ask for a "fast grievance" if you disagree with our decision to not give you a "fast appeal" or if we take an extension on our initial decision or appeal. See below for more detail.

Filing a grievance with WHA *Care*+

If you have a complaint, we encourage you to first call Member Services at the number displayed in Section 1 of this booklet. We will try to resolve any complaint that you might have over the phone. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this the WHA *Care*+ grievance procedure.

If we cannot resolve your complaint over the phone, we encourage you to send your grievance in writing to the Member Services Department. We will acknowledge your grievance in writing, within five (5) days after we receive it. We may need to obtain information from your physician or medical group in order to resolve your grievance, but will notify you of the resolution not later than thirty (30) days after we receive it.

For quality of care problems, you may also complain to the QIO

If you are concerned about the quality of care you received, including care during a hospital stay, you can also complain to an independent organization called the QIO. See Section 1 for more information about the QIO.

SECTION 12 Detailed information about how to make an appeal

What is the purpose of this section?

The purpose of this section is to give you more information about a topic that is summarized briefly in the previous section of this booklet (Section 11). Section 11 outlines the six possible steps in the appeals process for making complaints about your coverage or payment for your care. This section goes through the same six steps in more detail. Since Section 11 also gives general information about making complaints, and discusses how to deal with other types of problems besides problems with coverage or payment for care, **you should read Section 11 before you read this section.**

A note about terminology. In this Section, we tend to use simpler language instead of certain legal language, including terms that appear in the government regulations for the appeals process. For example, we generally say "initial decision" instead of "initial organization determination," and we generally use the word "fast" rather than "expedited" when referring to decisions that are made more quickly than the standard time frame. Instead of saying "adverse decision," we may say "deny your request," or "turn down your appeal". We use "independent review organization" rather than "independent review entity".

What are "complaints about your coverage or payment for your care"?

Complaints about your coverage or payment for your care are complaints you may have if you are not getting medical benefits and services you believe are covered for you as a plan member. This includes payment for care received while a member of WHA *Care+*. Complaints about your coverage or payment for your care include complaints about the following situations:

- If you are not getting the care you want, and you believe that this care is covered by WHA *Care+*
- If we will not authorize the medical treatment your doctor or other medical provider wants to

give you, and you believe that this treatment is covered by WHA *Care+*

- If you are being told that coverage for a treatment or service you have been getting will be reduced or stopped, and you feel that this could harm your health
- If you have received care that you believe is covered by WHA *Care+*, but we have refused to pay for this care because we say it is not covered

How does the appeals process work?

The six possible steps you can take to make complaints related to your coverage or payment for your care are described below. Here are a few things to keep in mind as you read the description of these steps in the appeals process:

- **Moving from one step to the next**. At each step, your request for care or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the medical care involved or on other factors.
- **"Initial decision" vs. "making an appeal".** Step 1 deals with the starting point for the appeals process. The decision made in Step 1 is called an "initial decision" or "organization determination." If you continue with your complaint by going on to Step 2, it is called making an "appeal" or a "request for reconsideration" of our initial decision because you are "appealing" for a change in the initial decision that was made in Step 1. Step 2, and all of the remaining possible steps, also involves *appealing* a decision.
- **Who makes the decision at each step**. In Step 1, you make your request for coverage of care or payment for care directly to us. We review this request, then make an initial decision. If our initial decision turns down your request, you can go on to Step 2, where you "appeal" this initial decision (asking us to reconsider). **After Step 2, your appeal goes outside of WHA, where people who are not connected to us conduct the review and make the decision.** To help ensure a fair, impartial decision, those who make the decision about your appeal in Steps 3-6 are part of (or in some way connected to) the Medicare program, the Social Security Administration, or the federal court system.

STEP 1: WHA makes an "initial decision" about your medical care, or about paying for care you have already received

What is an "initial decision"?

The "initial decision" made by WHA is the starting point for dealing with requests you may have about your coverage or payment for your care. With this decision, we inform you whether we will provide the medical care or service you request, or pay for a service you have already received. (This "initial decision" is sometimes called an "organization determination.") If our initial decision is to deny your request (this is sometimes called an "adverse initial decision"), you can "appeal" the decision by going on to Step 2 (see below). You may also go on to Step 2 if we fail to make a

timely "initial decision" on your request.

- If you ask us to pay for medical care you have already received, this is a request for an "initial decision" about payment for your care. You can call us at 1-888-563-2252, 1-916-563-2252 or (TTY) 1-888-877-5378 to get help in making this request.
- If you ask for a specific type of medical treatment from your doctor or other medical provider, this is a request for an "initial decision" about whether the treatment you want is covered by WHA *Care*+. Depending on the situation, your doctor or other medical provider may make this decision on behalf of WHA, or may ask us whether we will authorize the treatment. You may want to ask us for an initial decision without involving your doctor. You can call us at 1-888-563-2252, 1-916-563-2252 or (TTY) 1-888-877-5378 to ask for an initial decision.

When we make an "initial decision," we are giving our interpretation of how the benefits and services that are covered for members of WHA *Care*+ apply to your specific situation. This booklet and any amendments you may receive describe the benefits and services covered by WHA *Care*+, including any limitations that may apply to these services. This booklet also lists exclusions (services that are "not covered" by WHA *Care*+).

Who may ask for an "initial decision" about your medical care or payment?

You can ask us for an initial decision yourself, or you can name someone to do it for you. This person you name would be your *authorized representative*. You can name a relative, friend, advocate, doctor, or someone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and the person you want to act for you must sign and date a statement that gives this person legal permission to act as your authorized representative. This statement must be sent to us at:

WHA *Care*+, Attention: Appeals Department,
1331 Garden Highway, Suite 100, Sacramento, CA 95833

You can call us at 1-888-563-2252, 1-916-563-2252 or (TTY) 1-888-877-5378 to learn how to name your authorized representative.

You also have the right to have an attorney ask for an initial decision on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. You may want to contact the Department of Managed Health Care (DMCH) at 1-888-HMO-2219, (TTD) 1-877-688-9891.

"Standard decisions" vs. "fast decisions" about medical care

Do you have a request for medical care that needs to be decided more quickly than the standard time frame?

A decision about whether we will cover medical care can be a "standard decision" that is made within the standard time frame (typically within 14 days; see below), or it can be a "fast decision" that is made more quickly (typically within 72 hours; see below). A fast decision is sometimes called a 72-hour decision or an "expedited organization determination."

You can ask for a fast decision **only** if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for medical care. You cannot get a fast decision on requests for payment for care you have already received.)

Asking for a standard decision

To ask for a standard decision about medical care or payment for care, you or your authorized representative should mail or deliver a request in writing to the following address:

WHA *Care*+, Attention: Appeals Department,
1331 Garden Highway, Suite 100, Sacramento, CA 95833

Asking for a fast decision

You, any doctor, or your authorized representative can ask us to give a "fast" decision (rather than a "standard" decision) about medical care by calling us at 1-888-563-2252, 1-916-563-2252 or (TTY) 1-888-877-5378. Or, you can deliver a written request to:

WHA *Care*+, Attention: Appeals Department,
1331 Garden Highway, Suite 100, Sacramento, CA 95833

or fax it to 1-916-568-0126.

Be sure to ask for a "fast" or "72-hour" review.

Requests that are made outside of regular weekday business hours may be directed to your PCP. You can call your PCP at any time of the day, including evenings and weekends. Explain your condition to your doctor or the Physician on-call and they will direct your care. There will always be a doctor on call to help you. This physician will call you back and advise you about what to do.

- If **any** doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.
- If you ask for a fast initial decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast initial decision, we will send you a letter informing you that if you get a doctor's support for a "fast" review, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. It will also tell you about your right to ask for a "fast grievance." If we deny your request for a fast initial decision, we will instead give you a standard decision (typically within 14 calendar days; see below).

What happens when you request an "initial decision"?

What happens, including how soon we must decide, depends on the type of decision.

1. *For a decision about payment for care you already received.*

   We have 30 calendar days to make a decision after we have received your request. However, if we need more information, we can take up to 30 more days. You will be told in writing when

we make a decision. If we do not approve your request for payment, we must tell you why, and tell you how you can appeal this decision. If you have not received an answer from us within 60 calendar days of your request for payment, then the failure to receive an answer is the same as being told that your request was not approved. You may then appeal this decision. (An appeal is also called a reconsideration.) Step 2 tells how to file this appeal.

2. *For a standard initial decision about medical care.*

   We have up to 14 calendar days to make a decision after we have received your request, but we will make it sooner if your health condition requires. However, we are allowed to take up to an additional 14 calendar days to make a decision if you request the additional time, or if we need more time to gather information that may benefit you. For example, we may need more time to get information that would help us approve your request for medical care (such as medical records). When we take additional days, we will notify you in writing of this extension. If you feel that we should not take additional days, you can make a specific type of complaint called a "grievance." Section 11 of this booklet tells how to file a grievance.

   We will tell you in writing of our initial decision concerning the medical care you have requested. You will receive this notification when we make our decision, under the time frame explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. Step 2 tells how to file this appeal.

   If you have not received an answer from us within 14 calendar days of your request for the initial decision, the failure to receive an answer is the same as being told that your request was not approved, and you have the right to appeal. Step 2 tells how to file this appeal. If we tell you that we extended the number of days needed for a decision and you have not received an answer from us by the end of the extension period, the failure to receive an answer is the same as being told that your request was not approved, and you do have the right to appeal.

3. *For a fast initial decision about medical care.*

   If you receive a "fast" review, we will give you our decision about your medical care within 72 hours after you or your doctor ask for a "fast" review -- sooner if your health requires. However, we are allowed to take up to 14 more calendar days to make this decision if we find that some information is missing which may benefit you, or if you need more time to prepare for this review. If you feel that we should not take any additional days, you can make a specific type of complaint called a "grievance." Section 11 of this booklet tells how to file a grievance.

   We will tell you our decision by phone as soon as we make the decision. Within three calendar days after we tell you of our decision in person or by phone, we will send you a letter that explains the decision. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), this is the same as denying your request. If we deny your request for a fast decision, you may file a grievance. Section 11 of this booklet tells how to file a grievance.

What happens next if we decide completely in your favor?

If we make an "initial decision" that is completely in your favor, what happens next depends on the situation.

1. *For a decision about payment for care you already received.*

We must pay within 30 calendar days of your request for payment, unless your request has errors or missing information. Then, we must pay within 60 calendar days.

2. *For a standard decision about medical care.*

   We must authorize or provide you with the care you have requested as quickly as your health requires, but no later than 14 calendar days after we received the request you made for the initial decision. If we extended the time needed to make the decision, we will approve or provide your medical care when we make our decision.

3. *For a fast decision about medical care.*

   We must authorize or provide you with the medical care you have requested within 72 hours of receiving your request. If your health would be affected by waiting this long, we must provide it sooner.

What happens next if we deny your request?

If we deny your request, we may decide *completely* or only *partly* against you. For example, if we deny your request for payment for care that you have already received, we may say that we will pay nothing or only part of the amount you requested. In denying a request for medical care, we might decide not to approve any of the care you want, or only some of the care you want. If any initial decision does not give you *all* that you requested, you have the right to ask us to reconsider the decision. (See Step 2.)

STEP 2: If we deny part or all of your request in Step 1, you may ask us to reconsider our decision. This is called an "appeal" or "request for reconsideration".

Please call us at 1-888-563-2252, 1-916-563-2252 or (TTY) 1-888-877-5378 if you need help in filing your appeal. You may ask us to reconsider the initial decision we made in Step 1, even if only part of our decision is not what you requested. When we receive your request to reconsider the initial decision, we give the request to different people than those who were involved in making the initial decision. This helps ensure that we will give your request a fresh look.

How you make your appeal depends on whether it is about payment for care you already received, or about authorizing medical care. If your appeal concerns a decision we made about authorizing medical care, then you and/or your doctor will first need to decide whether you need a "fast" appeal. The procedures for deciding on a "standard" or a "fast" *appeal* are the same as those described for a "standard" or "fast" *initial decision* in Step 1. Please see the discussion in Step 1 under "Do you have a request for medical care that needs to be decided more quickly than the standard time frame?" and "Asking for a fast decision".

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to the issue, or you may want to get the doctor's records or the doctor's

opinion to help support your request. You may need to give the doctor a written request to get information.

You can give us your additional information in any of the following ways:

- In writing, to **WHA *Care*+, Attention: Appeals Department, 1331 Garden Highway, Suite 100, Sacramento, CA 95833**
- By fax, at 1-916-568-0126
- By telephone -- if it is a "fast" appeal -- at 1-888-563-2252, 1-916-563-2252 or (TTY) 1-888-877-5378
- In person, at 1331 Garden Highway, Suite 100, Sacramento, CA 95833

You also have the right to ask us for a copy of information regarding your appeal. You can call or write us at **WHA *Care*+, Attention: Appeals Department, 1331 Garden Highway, Suite 100, Sacramento, CA 95833** or by calling 1-888-563-2252, 1-916-563-2252 or (TTY) 1-888-877-5378.

How do you file your appeal of the initial decision?

The rules about who may file an appeal in Step 2 are the same as the rules about who may ask for an "initial decision" in Step 1. Follow the instructions in Step 1 under "Who may ask for an 'initial decision' about medical care or payment?"

Either you, someone you appoint, or your provider may file this appeal.

However, providers who do not have a contract with WHA must sign a "waiver of payment" statement that says that they will not ask you to pay for the medical service under review, regardless of the outcome of the appeal.

How soon must you file your appeal?

The appeal should be given to us in writing at **WHA *Care*+, Attention: Appeals Department, 1331 Garden Highway, Suite 100, Sacramento, CA 95833**, within 60 calendar days after we notify you of the initial decision from Step 1. We can give you more time if you have a good reason for missing the deadline.

You may also send your appeal to your Social Security Administration office or, if you are a railroad retiree, to a Railroad Retirement Board office. Please note that sending your appeal to either of these offices instead of to us will cause a delay when we begin the appeal, since these offices must forward your appeal request to us.

What if you want a "fast" appeal?

The rules about asking for a "fast" appeal in Step 2 are the same as the rules about asking for a "fast" initial decision in Step 1. If you want to ask for a "fast" appeal in Step 2, please follow the instructions in Step 1 under "Asking for a fast decision".

How soon must we decide on your appeal?

How quickly we decide on your appeal depends on the type of appeal:

1. *For a decision about payment for care you already received.*

   After we receive your appeal, we have 60 calendar days to make a decision. If we do not decide within 60 calendar days, your appeal *automatically* goes to Step 3, where an independent organization will review your case.

2. *For a standard decision about medical care.*

   After we receive your appeal, we have up to 30 calendar days to make a decision, but will make it sooner if your health condition requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more calendar days to make our decision. If we do not tell you our decision within 30 calendar days (or by the end of the extended time period), your request will *automatically* go to Step 3, where an independent organization will review your case.

3. *For a fast decision about medical care.*

   After we receive your appeal, we have up to 72 hours to make a decision, but will make it sooner if your health requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more calendar days to make our decision. If we do not tell you our decision within 72 hours (or by the end of the extended time period), your request will automatically go to Step 3, where an independent organization will review your case.

What happens next if we decide completely in your favor?

1. *For a decision about payment for care you already received.*

   We must pay within 60 calendar days of the day we received your request for us to reconsider our initial decision. If we decide only partially in your favor, your appeal automatically goes to Step 3, where an independent organization will review your case.

2. *For a standard decision about medical care.*

   We must authorize or provide you with the care you have asked for as quickly as your health requires, but no later than 30 calendar days after we received your appeal. If we extend the time needed to decide your appeal, we will authorize or provide your medical care when we make our decision.

3. *For a fast decision about medical care.*

   We must authorize or provide you with the care you have asked for within 72 hours of receiving your appeal -- or sooner, if your health would be affected by waiting this long. If we extended the time needed to decide your appeal, we will authorize or provide your medical care at the time we make our decision.

What happens next if we deny your appeal?

If we deny any part of your appeal in Step 2, then your appeal *automatically* goes on to Step 3 where an independent organization will review your case. This independent review organization

contracts with the federal government and is not part of WHA. We will tell you in writing that your appeal has been sent to this organization for review. How quickly we must forward your appeal to the independent review organization that performs the review in Step 3 depends on the type of appeal:

1. *For a decision about payment for care you already received.*

   We must send all the information about your appeal to the independent review organization within 60 calendar days from the date we received your appeal in Step 2.

2. *For a standard decision about medical care.*

   We must send all of the information about your appeal to the independent review organization as quickly as your health requires, but no later than 30 calendar days after we received your appeal in Step 2.

3. *For a fast decision about medical care.*

   We must send all of the information about your appeal to the independent review organization within 24 hours of our decision.

STEP 3: If we deny any part of your appeal in Step 2, your appeal automatically goes on for review by a government-contracted independent review organization

What independent review organization does this review?

In Step 3, your appeal is given a new review by an outside, independent review organization that has a contract with CMS (Centers for Medicare & Medicaid Services), the government agency that runs the Medicare program. This organization has no connection to us. We will tell you when we have sent your appeal to this organization. You have the right to get a copy from us of your case file that we sent to this organization.

How soon must the independent review organization decide?

After the independent review organization receives your appeal, how long the organization can take to make a decision depends on the type of appeal:

1. *For an appeal about payment for care,* the independent review organization has up to 60 calendar days to make a decision.

2. *For a standard appeal about medical care,* the independent review organization has up to 30 calendar days to make a decision. This time period can be extended by up to 14 calendar days if more information is needed and the extension will benefit you.

3. *For a fast appeal about medical care,* the independent review organization has up to 72 hours to make a decision. This time period can be extended by up to 14 calendar days if more information is needed and the extension will benefit you.

If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. *For an appeal about payment for care,*

   We must pay within 30 calendar days after receiving the decision.

2. *For a standard appeal about medical care,*

   We must *authorize* the care you have asked for within 72 hours after receiving notice of the decision from the independent review organization, or *provide* the care as quickly as your health requires, but no later than 14 calendar days after receiving the decision.

3. *For a fast appeal about medical care,*

   We must authorize or provide you with the care you have asked for within 72 hours of receiving the decision.

What happens next if the review organization decides against you (either partly or completely)?

The independent review organization will tell you in writing about its decision and the reasons for it. You may continue your appeal by asking for a review by an Administrative Law Judge (see Step 4), provided that the dollar value of the medical care or the payment in your appeal is $100 or more.

You must make a request for review by an Administrative Law Judge in writing within 60 calendar days after the date you were notified of the decision made in Step 3. You can extend this deadline for good cause. You have a choice about where you send your written request:

- Directly to the independent review organization that reviewed your appeal in Step 3. They will then send your request along with your appeal information to the Administrative Law Judge who will hear your appeal.
- To WHA, or to your local Social Security Administration office. If you do this, starting Step 4 will take longer because your request must first be forwarded to the independent review organization that reviewed your appeal in Step 3. The independent review organization will then send your request along with your appeal information to the Administrative Law Judge who will hear your appeal.

STEP 4: If the organization that reviews your case in Step 3 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

As stated in Step 3, if the independent review organization does not rule completely in your favor, you may ask them to forward your appeal for a review by an Administrative Law Judge. During this review, you may present evidence, review the record, and be represented by council. The Administrative Law Judge will not review the appeal if the dollar value of the medical care is less than $100. If the dollar value is less than $100, you may not appeal any further.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor

We must pay for, authorize, or provide the service you have asked for within 60 calendar days from the date we receive notice of the decision. We have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Step 5).

If the Judge rules against you

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Step 5). The letter you get from the Administrative Law Judge will tell you how to request this review.

STEP 5: Your case may be reviewed by a Medicare Appeals Council

This Council will first decide whether to review your case

The Medicare Appeals Council does not review every case it receives. When it gets your case, it will first decide whether to review your case. If they decide not to review your case, then either you or WHA may request a review by a Federal Court Judge. However, the Federal Court Judge will only review cases when the amount involved is $1,000 or more. If the dollar value is less than $1,000, you may not appeal any further.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If the Council decides in your favor

We must pay for, authorize, or provide the medical service you have asked for within 60 calendar days from the date we receive notice of the decision. However, we have the right to appeal this decision by asking a Federal Court Judge to review the case (Step 6), provided the amount involved is at least $1,000. If the dollar value is less than $1,000, the Council's decision is final.

If the Council decides against you

If the amount involved is $1,000 or more, you or we have the right to continue your appeal by asking a Federal Court Judge to review the case (Step 6). If the value is less than $1,000, you may not take the appeal any further.

STEP 6: Your case may go to a Federal Court

If the contested amount is $1,050 or more, you or we may ask a Federal Court Judge to review the case.

SECTION 13 Leaving WHA *Care*+ and your choices for continuing Medicare after you leave

What is "disenrollment"?

"Disenrollment" from WHA *Care*+ means **ending your membership** in WHA *Care*+. Disenrollment can be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave WHA *Care*+ because you have decided that you *want* to leave. You can do this for any reason.
- There are also a few situations where you would be *required* to leave. For example, you would have to leave WHA *Care*+ if you move out of our geographic service area or if WHA *Care*+ leaves the Medicare program. We are not allowed to ask you to leave the plan because of your health.

Whether leaving the plan is your choice or not, this section explains your Medicare coverage choices after you leave and the rules that apply.

Until your membership officially ends, you must keep getting your Medicare services through WHA *Care+ or you will have to pay for them yourself*

If you leave WHA *Care*+, it takes some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect later in this section). While you are waiting for your membership to end, you are still a member and must continue to get your care as usual through WHA *Care*+. If you get services from doctors or other medical providers who are **not** plan providers before your membership in WHA *Care*+ ends, neither WHA nor the Medicare program will pay for these services, with just a few exceptions. The exceptions are urgently needed care, care for a medical emergency, out-of-area renal (kidney) dialysis services, and care that has been approved by us. There is another possible exception, if you happen to be hospitalized on the day your membership ends. If this happens

to you, call Member Services at the number displayed in Section 1 of this booklet to find out if your hospital care will be covered by WHA *Care*+. If you have any questions about leaving WHA *Care*+, please call us at Member Services.

What are your choices for continuing Medicare if you leave WHA Care+?

If you leave WHA *Care*+, one choice for continuing with Medicare is to go to **Original Medicare.** You may also have the choice of joining another **Medicare managed care plan** or a **Medicare Private Fee-for-Service plan** *if* any of these types of plans are available in your area and they are accepting new members.

- **Original Medicare** is available throughout the country. It is a pay-per-visit or "fee-for-service" health plan that lets you go to any doctor, hospital, or other health care provider *who accepts Medicare*. You must pay a deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). Original Medicare is the way most people get their Medicare Part A and Part B health care
- **Medicare Managed Care Plans** (such as HMOs or PPOs) are available in some parts of the country. In HMOs you go to the doctors, hospitals, and other providers *that are part of the plan*. In PPOs, you can usually see any doctor but you may pay more to see doctors, hospitals, and other providers that are *not* part of the plan. These plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescriptions drugs. WHA *Care*+ is a Medicare managed care plan offered by WHA.
- **Medicare Private Fee-for-Service Plans** are available in some parts of the country. In Private Fee-for-Service plans, you may go to *any* Medicare-approved doctor or hospital that accepts the plan's payment. The Private Fee-for-Service plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay more for Medicare-covered benefits. You may get extra benefits that Original Medicare does not cover. Private Fee-for-Service plans are *not* the same as Medigap (Medicare supplement insurance) policies.

When can you change your Medicare choices?

All through the year, everyone with Medicare (including members of WHA *Care*+) is allowed to change from their current way of getting Medicare to one of their other choices. As we have explained above, you have one or more of the following choices about how you get your Medicare coverage. They are:

- **Original Medicare**. This choice is available to you throughout the year.
- A **Medicare Managed Care Plan.** This choice is available to you **if** there are Medicare managed care plans in your area, and **if** they are accepting new members when you want to join. There is a yearly period from November 15 through December 31 when all Medicare Advantage plans must accept new members (unless unusual circumstances

apply). (Medicare Advantage is the new name for Medicare + Choice).

- A **Medicare Private Fee-for-Service plan.** This choice is available to you **if** there are Medicare Private Fee-for-Service plans in your area, and **if** they are accepting new members when you want to join. There is a yearly period from November 15 through December 31 when all Medicare Private Fee-for-Service plans must accept new members (unless unusual circumstances apply).

In most cases, your disenrollment date will be the first day of the month that comes *after* the month we receive your request to leave. For example, if we receive your request to leave during the month of February, your disenrollment date will be March 1. There is an exception: if we receive your request between November 15 and 30, the change will take effect on January 1, unless you specifically ask for a disenrollment date of December 1.

What should you do if you decide to leave WHA Care+*?*

If you want to leave WHA *Care*+, what you must do to leave depends on whether you want to change to Original Medicare or to one of your other choices.

How to change from WHA *Care*+ to Original Medicare

Do you need to buy a Medigap (Medicare supplement insurance) policy?

If you want to change from WHA *Care*+ to Original Medicare, you should think about whether you need to buy a Medigap policy to supplement your Original Medicare coverage. For Medigap advice, you should contact HICAP (the phone number is in Section 1). You can ask HICAP about how and when to buy a Medigap policy if you need one. HICAP can tell you if you have a guaranteed issue right to buy a Medigap policy.

If you have a "**guaranteed issue right,**" this means that the Medigap insurer must sell you a Medigap policy , even if you have health problems. This is a special, temporary right, which means that if you decide to change to Original Medicare you have a limited time to buy a Medigap policy on a guaranteed issue basis. For example, you have a guaranteed issue right to buy a Medigap policy if you are in a Medicare managed care plan "trial period" and you change to Original Medicare. Generally, a Medicare managed care plan trial period begins on the date of "first time" enrollment in a Medicare health plan (other than Original Medicare) and ends 12 months later. You may be in a Medicare managed care plan trial period if in the past 12 months you: (1) dropped a Medigap policy to join a Medicare health plan for the first time; or (2) joined a Medicare health plan upon first becoming entitled to Medicare at age 65. Under certain circumstances, if you lose your health plan coverage while you are still in a trial period, the trial period can last for an extra 12 months. HICAP can tell you about other situations where you may have guaranteed issue rights.

If you do buy a Medigap policy, you still have to follow the instructions below for changing from WHA *Care*+ to Original Medicare. (Buying a Medigap policy does not switch you from WHA *Care*+ to Original Medicare. A Medigap sales person or insurance agent cannot cancel your WHA *Care*+ membership and put you in Original Medicare.)

How to change from WHA Care+ *to Original Medicare*

If you decide to change from WHA *Care*+ to Original Medicare, you must tell us (or one of the offices listed below) that you want to leave WHA *Care*+. You do *not* have to notify Original Medicare, because you will automatically be in Original Medicare when you leave WHA *Care*+. Here is how it works:

1. First, use any of the following ways to tell us that you want to leave WHA *Care*+:
    - You can write or fax a letter to us or fill out a disenrollment form and send it to Member Services at **WHA *Care*+,1331 Garden Highway, Suite 100, Sacramento, CA, 95833** or to our fax number at **1-916-568-0126***.* Be sure to sign and date your letter. To get a disenrollment form, call us at the Member Services telephone number displayed in Section 1 of this booklet.
    - You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, which is the national Medicare help line. TTY Users should call 1-877-486-2048.
    - You can contact your nearest Social Security office or, if you have Railroad Retirement benefits, you can contact the Railroad Retirement Board office. Section 1 tells you how to contact these offices.
2. We will then send you a letter that tells you when your membership will end. This is your **disenrollment date** – the day you officially leave WHA *Care*+. In most cases, your disenrollment date will be the first day of the month that comes after the month we receive your request to leave. For example, if we receive your request to leave during the month of February, your disenrollment date will be March 1. There is an exception: the disenrollment date for requests received between November 15 and November 30 are effective on January 1, unless you specifically ask us to disenroll you on December 1. Remember, while you are waiting for your membership to end, you are still a member of WHA *Care*+ and must continue to get your medical care as usual through WHA *Care*+.
3. On your disenrollment date, your membership in WHA *Care*+ ends, and you can start using your red, white, and blue Medicare card to get services under Original Medicare**.** You will not get anything in writing that tells you that you have Original Medicare, because you will *automatically* be in Original Medicare when you leave WHA *Care*+. (Call Social Security at 1-800-772-1213 if you need a new red, white, and blue Medicare card.)

How to change from WHA *Care*+ to *another* Medicare managed care plan or to a Private Fee-for-Service Plan

If you want to change from WHA *Care*+ to a different Medicare managed care plan or to a Private Fee-for-Service plan, here is what to do:

1. Contact the plan you want to join to be sure it is accepting new members.
2. If the plan is accepting new members, apply for membership in the plan. **Once you are enrolled in your new plan, your membership in WHA *Care*+ will *automatically* end**. This means that you do not need to tell us that you are leaving. However, we do encourage you to tell us why you left.

3. Your new plan will tell you in writing the date when your membership in that plan begins, and your membership in WHA *Care*+ will end on that same day (this will be your "disenrollment date"). Remember, you are still a member until your disenrollment date, and must continue to get your medical care as usual through WHA *Care*+ until the date your membership ends.

What happens to you if WHA *leaves the Medicare program or* WHA *Care+ leaves the area where you live?*

If we leave the Medicare program or change our service area so that it no longer includes the area where you live, we will tell you in writing. If this happens, your membership in WHA *Care*+ will end, and you will have to change to another way of getting your Medicare benefits. All of the benefits and rules described in this booklet will continue until your membership ends. This means that you must continue to get your medical care in the usual way through WHA *Care*+ until your membership ends.

Your choices will always include Original Medicare. Your choices may also include joining another Medicare managed care plan, or a Private Fee-for-Service plan, if these plans are available in your area and are accepting new members. Once we have told you in writing that we are leaving the Medicare program or the area where you live, you may change to another way of getting your Medicare benefits at any time. If you decide to change from WHA *Care*+ to Original Medicare, you will have the right to buy a Medigap policy regardless of your health. This is called a "guaranteed issue right" and it is explained earlier in this section under the heading, "Do you need to buy a Medigap (Medicare supplement insurance) policy?"

WHA has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs Medicare. This contract renews each year. At the end of each year, the contract is reviewed, and either WHA or CMS can decide to end it. It is also possible for our contract to end at some other time, too. You will get 90 days advance notice in this situation. If the contract is going to end, we will generally tell you 90 days in advance. Your advance notice may be as little as 30 days or even fewer days if CMS must end our contract in the middle of the year.

You must leave WHA *Care+ if you move out of the service area or are away from the service area for more than six months in a row*

If you plan to move or take a long trip, please call Member Services at the number displayed in Section 1 of this booklet to find out if the place you are moving to or traveling to is in plan's service area. If you move permanently out of our service area, or if you are away from our service area for more than six months in a row, you will need to leave ("disenroll" from) WHA *Care*+. In these situations, if you do not leave on your own, we must end your membership ("disenroll" you). An earlier part of this section tells about the choices you have if you leave WHA *Care*+ and explains how to leave.

Under certain conditions WHA *can end your membership and make you leave the plan*

We *cannot* ask you to leave the plan because of your health

No member of any Medicare health plan can be asked to leave the plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave WHA *Care*+ because of your health, you should call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), 24 hours a day, 7 days a week, which is the national Medicare help line.

We *can* ask you to leave the plan under certain special conditions

If any of the following situations occur, we will need to end your membership in WHA.

- If you move out of our geographic service area or live outside the plan's service area for more than six months at a time (see Section 3 for information about the plan's service area).
- If you do *not* stay continuously enrolled in both Medicare Part A and Medicare Part B (see Section 9 for information about staying enrolled in Part A and Part B).
- If you give us information on your enrollment form that you know is false or deliberately misleading, and it affects whether or not you can enroll in WHA *Care*+.
- If you behave in a way that is unruly, uncooperative, disruptive, or abusive, and this behavior seriously affects our ability to arrange or provide medical care for you or for others who are members of WHA *Care*+. We cannot make you leave WHA *Care*+ for this reason unless we get permission first from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.
- If you let someone else use your plan membership card to get medical care. Before we ask you to leave WHA *Care*+ for this reason, we must refer your case to the Inspector General, and this may result in criminal prosecution.
- If you do not pay the plan premiums, we will tell you that you have a 90-day grace period during which you can pay the plan premiums before you are required to leave WHA *Care*+.

You have the right to make a complaint if we ask you to leave WHA *Care+*

If we ask you to leave WHA *Care*+, we will tell you our reasons in writing and explain how you can file a complaint against us if you want to.

SECTION 14 Legal Notices

Notice about governing law

Many different laws apply to this Evidence of Coverage. Some additional provisions may apply to your situation because they are required by law. This can affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the State of California may apply.

Notice about non-discrimination

When we make decisions about the provision of health care services, we do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare managed care plans, like WHA, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that receive federal funding, and any other laws and rules that apply for any other reason.

Section 15 Definitions of some words used in this booklet

For the terms listed below, this section either gives a definition or directs you to a place in this booklet that explains the term

Appeal -- Sections 11 and 12 explain about appeals, including the process involved in making an appeal.

Benefit period -- For both WHA *Care*+ and Original Medicare, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period *begins* on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period *ends* when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. The type of care you actually receive during the stay determines whether you are considered to be an inpatient for SNF stays, but not for hospital stays.

- You are an inpatient in a SNF only if your care in the SNF meets certain skilled level of care standards. Specifically, in order to have been an inpatient while in a SNF, you must need daily skilled nursing or skilled rehabilitation care, or both. (Section 8 tells what is meant by skilled care.)
- Generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital (the type of care you actually receive in the hospital does not determine whether you are considered to be an inpatient in the hospital).

Centers for Medicare & Medicaid Services (CMS) -- The Federal Agency that runs the Medicare program (CMS was formerly known as the Health Care Financing Administration). Section 1 tells how you can contact CMS.

Covered services -- The general term we use in this booklet to mean all of the health care services and supplies that are covered by WHA *Care*+. Covered services are listed in the Benefits Chart in Section 5.

Disenroll or disenrollment -- The process of ending your membership in WHA *Care*+. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 13 tells about disenrollment.

Durable medical equipment is equipment needed for medical reasons, which is sturdy enough to be used many times without wearing out. A person normally needs this kind of equipment only when ill or injured. It can be used in the home. Examples of durable medical equipment include wheelchairs, hospital beds, or equipment that supplies a person with oxygen.

Emergency care -- Covered services that are 1) furnished by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition. Section 4 tells about emergency services.

Evidence of coverage and disclosure information -- This document, along with your enrollment form, which explains the covered services, defines our obligations, and explains your rights and responsibilities as a member of the WHA *Care*+.

Grievance -- Section 11 explains about grievances.

Medically necessary -- Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of you or your doctor.

Medicare -- The federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Organization -- A public or private organization licensed by the State as a risk-bearing entity that is under contract with the Centers for Medicare & Medicaid Services (CMS) to provide covered services. Medicare Advantage Organizations can offer one or more Medicare Advantage Plans. WHA is a Medicare Advantage Organization. (Medicare Advantage is the new name for Medicare + Choice.)

Medicare Advantage Plan -- A benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at a uniform premium and uniform level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. A Medicare Advantage Organization may offer more than one plan in the same service area. WHA *Care*+ is a Medicare Advantage Plan. (Medicare Advantage is the new name for Medicare + Choice.)

Medicare Cost Plan -- A specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all people with Medicare living in the service area covered by the Plan. A company offering a Cost Plan may offer more than one plan in the same service area. Members under this plan may use Original Medicare benefits from any Medicare provider.

"Medigap" (Medicare supplement insurance) policy – Many people who get their Medicare through Original Medicare buy "Medigap" or Medicare supplement insurance policies to fill "gaps" in Original Medicare coverage.

Member (member of WHA *Care*+, or "plan member") -- A person with Medicare who is eligible to get covered services, who has enrolled in WHA *Care*+, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member services -- A department within WHA responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 1 for information about how to contact Member Services.

Non-plan provider or non-plan facility -- A provider or facility that we have **not** arranged with to coordinate or provide covered services to members of WHA *Care*+. Non-plan providers are providers that are not employed, owned, or operated by WHA and are not under contract to deliver covered services to you. As explained in this booklet, most services you get from non-plan

providers are not covered by WHA or Original Medicare.

Original Medicare -- A plan that is available everywhere in the United States. Some people call it "traditional Medicare" or "fee-for-service" Medicare. Original Medicare is the way most people get their Medicare Part A and Part B health care. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider *who accepts Medicare*. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Plan provider -- "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**plan providers**" when they are part of WHA *Care*+. When we say that plan providers are "part of WHA *Care*+," this means that we have arranged with them to coordinate or provide covered services to members of WHA *Care*+. WHA pays plan providers based on the contracts it has with the providers.

Primary Care Provider (PCP) -- A health care professional who is trained to give you basic care. Your PCP is responsible for providing or authorizing covered services while you are a plan member. Section 3 tells more about PCPs.

Prior authorization -- Approval in advance to get services. Some services are covered only if your doctor or other plan provider gets "prior authorization" from WHA. Covered services that need prior authorization are marked in the Benefits Chart.

Quality Improvement Organization (QIO) -- Groups of practicing doctors and other health care experts who are paid by the Federal Government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by doctors in inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, private fee-for-service plans and ambulatory surgical centers. See Section 1 for information about how to contact the QIO in your state and Section 11 for information about making complaints to the QIO.

Referral -- Your PCP's or his/her plan medical group's approval for you to see a certain specialist or to receive certain covered services.

Rehabilitation services -- These services include physical therapy, cardiac rehabilitation, speech and language therapy, and occupational therapy that are provided under the direction of a plan provider. See Section 8 for more information.

Service area -- Section 3 tells about the WHA *Care*+ service area. "Service area" is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a particular plan offered by a Medicare Health Plan.

Urgently needed care -- Section 4 explains about urgently needed services. These are different from emergency services.

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