University of California Covered Services Summary
WHA Care+ Plan Year 2003 - UC 107A

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

OUTPATIENT SERVICES — YOU PAY

Office visits for medical care .....$10 copayment
Preventive physical examinations .....$10 copayment
Eye and hearing examination .....$10 copayment
Immunizations .....Covered in full
Consultation, diagnosis and treatment by a plan specialist .....$10 copayment
Maternity care, after the initial diagnosis, pre and post natal care.....Covered in full
Laboratory, x-ray, (including mammography)……..Covered in full
Allergy tests and treatment .....Covered in full
Short-term physical therapy, speech pathology services and occupational therapy .....$10 copayment

INPATIENT HOSPITALIZATION — $250 PER ADMISSION

- Semi-private room and board for acute care (private room when determined medically necessary by a Contracted Provider)
- Physicians' services, including surgeons, consultants and nursing services
- Laboratory tests, x-rays, other radiology services
- Medical, surgical, and cardiac intensive care
- Medical supplies and appliances
- Special Care units, Medical Rehab Services
- Special Duty Nurse when prior authorized .....

SKILLED NURSING FACILITY

Semi-private room and board in a skilled nursing facility, when medically necessary and arranged by a primary care physician, including drugs, meals and prescribed ancillary services for up to 100 days in a benefit period with prior authorization ....
..... Covered in full

HOSPICE

Hospice ..... Covered in full
(when enrolled in a Medicare -certified Hospice, services are reimbursed directly by Medicare)

OUTPATIENT PRESCRIPTION MEDICATION*

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

Mail Order (90 day supply)
Generic……..……$20 copay
Brand Name……..……..……$40 copay
Non-formulary…….……..$70 copay

Drugs for the treatment of sexual dysfunction…….. 50% copay

***COPAYMENTS FOR PRESCRIPTION MEDICATIONS DO NOT CONTRIBUTE TO THE MAXIMUM COPAYMENT LIABILITY.**

HOME HEALTH CARE — YOU PAY

Part-time skilled nursing care, Part-time home health aide .....Covered in full
Medical supplies & equipment provided by the agency .....Covered in full

BEHAVIORAL HEALTH AND CHEMICAL DEPENDENCY

Mental Health
Outpatient services ..... $10 copayment

Inpatient Mental health care in a Medicare approved psychiatric hospital ……..……$250 per admission

Chemical Dependency
Outpatient services for detoxification and for medical conditions associated with substance abuse, including rehabilitation services. $10 copayment

Inpatient services for inpatient detoxification and for medical Conditions associated with substance abuse at a WHA acute care facility, including rehabilitation services
…….$250 per admission

OTHER HEALTH SERVICES

Eyeglasses, frames and lenses .....$20 copayment
(At Contracted Provider every 24 months)
Hearing Aids, one device per ear every 36 months ($2000 benefit maximum) ..... $10 copayment
Durable Medical Equipment and prosthetic devices when prior authorized……Covered in full
Chiropractic care for subluxation of the spine. ..... $10 copayment
Podiatry Services for medically necessary treatment.....$10 copayment
Ambulance services worldwide, when medically necessary ..... Covered in full

EMERGENCY SERVICES /URGENT CARE
Covered in full worldwide.

Emergency Room .....$50 copayment
(Copayment waived if admitted)

Urgent Care Facility .....$50 copayment

Emergency admission worldwide
For unlimited days…….$250 per admission

MAXIMUM COPAYMENT LIABILITY*

MAXIMUM COPAYMENT LIABILITY PER CALENDAR YEAR ARE LIMITED TO:

INDIVIDUAL ……..…$1,000
FAMILY ……$3,000

General Exclusions and Limitations

This is a Summary only, consult the Combined Evidence of Coverage and Disclosure Information for exact exclusions and limitations.

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

- Non-Urgently Needed Services or Non-Emergency Services and supplies rendered by non-Contracting Providers without written referral by the Member's Primary Care Physician.
- Homemaker services, except for limited coverage in accordance with Medicare guidelines.
- Long-term services beyond those which Medicare would cover, including, but not limited to, Skilled Nursing Care and respite care, except as determined by WHA to be less costly alternatives to the basic minimum benefits.
- Infertility testing or treatment.
- Orthopedic shoes, unless they are part of a leg brace and are included in the orthopedist's charge, except *WHA Care+* will cover therapeutic shoes for those suffering from diabetic foot disease.
- Experimental medical or surgical procedures, services or supplies. Please refer to the "Section 1 – Health Care Terms" in the Combined Evidence of Coverage and Disclosure Information for "Experimental" criteria.
- Cosmetic services and supplies are excluded.
- Speech, Occupational and Physical Therapy which is **not** secondary to a medical condition, but is a result of one of the following conditions: a)Psychosocial speech delay and language development; b) Mental Retardation, Downs Syndrome, Autism or Dyslexia; c) Other syndromes attributing to perceptual and conceptual dysfunctions, attention deficit disorder or behavioral problems; and d) Developmental articulation and other language disorders.
- Penile Prostheses are excluded unless prescribed by a Participating Physician and determined to be Medically Necessary (e.g., secondary to penile trauma, tumor, or physical disease to the circulatory system or nerve supply), and are not of a psychological cause.
- Vision therapy, surgical procedures for the correction of visual acuity in lieu of eyeglasses or contact lenses (except for intraocular lenses in connection with cataract removal).
- Services or supplies in connection with the storage of body parts, fluids or tissues, except for autologous blood.
- Dental care, except for (a) non-dental surgical and hospitalization procedures incidental to facial fractures, tumors or congenital defects, such as cleft lip or cleft palate, or (b) Surgery on the maxilla or mandible to correct temporomandibular joint disease (TMJ) or (c) other medical conditions, when Medically Necessary and Prior Authorized.
- Any services or supplies provided by a person who lives in the Member's home, or by an immediate relative of the Member.
- Routine foot care (e.g., treatment of or to the feet for corns, calluses or toenails), except when Medically Necessary. This exclusion includes Orthotic Devices for routine foot care. This exclusion does not include special footwear incident to foot disfigurement.
- Acupuncture, acupressure, biofeedback, sex therapy, dance therapy and recreational therapy.
- Embryo transfers and any services and supplies related to donor sperm or sperm preservation for artificial insemination, are excluded, including all services involved in surrogacy.
- Infertility testing and treatment, including services and supplies in connection with the reversal of voluntary sterilization.
- Transsexual surgery.
- Custodial care, or services and supplies furnished by an institution, which is a place for rest and provides non-nursing supervision of the patient.
- Smoking cessation products and programs.
- Repair and replacement of DME, Orthotics or Prosthetics, when necessitated by the Member's abuse, misuse or loss.
- Over-the-counter supplies or equipment that may be obtained without a prescription.
- Services and supplies that are in connection with the donation of organs, except for services related to Medically Necessary non-experimental organ transplants where the Member is the organ recipient.
- Weight control surgery or procedures, except for the Medically Necessary treatment of morbid obesity.
- Private duty nurses.

Prescription Medication Exclusions

- Covered prescription medications are limited to a 30-day supply, with the payment of a single Copayment. Prescriptions for controlled substances and other drugs not intended for continuous use may be limited to a smaller quantity per Copayment.
- Covered prescription medications that are to be taken beyond 60 days are considered maintenance medications, and may be obtained through WHA's Mail Order Program. The initial prescription for maintenance medications may be dispensed through a Participating Pharmacy (limited to a 30-day supply). Subsequent refills for a 90-day supply may be obtained with the payment of two 30-day copayments through the mail order program.
- Viagra and other episodic drugs for the treatment of sexual dysfunction are covered at a 50% copayment. Viagra is limited to 8 pills per 30-day supply.
- Over-the-counter medications or medications that do not require a prescription are excluded (except for insulin and insulin syringes with needles for diabetics, and other supplies and equipment for the treatment of diabetes).
- Prescriptions written by dentists are excluded.
- Nicotine gum, nicotine nasal spray and nicotine patches are excluded.
- Medications that are experimental/investigational or not approved for use by the Food and Drug Administration for the condition indicated are excluded.

Western Health Advantage

WHA Care+

Medicare+Choice Plan

UNIVERSITY OF CALIFORNIA

Combined Evidence of Coverage
and
Disclosure Information

Year
2003

WHA Care+
Western Health Advantage
1331 Garden Highway, Suite 100
Sacramento, CA 95833-9773
(916) 563-2250 or (888) 563-2250
TTY (888) 877-5378

Reference Page

Group Number: 00-1121

Plan: 107A

Please fill in the following information for your reference:

Your *WHA Care+* membership number _____
(located on your membership card)

Your Effective Date of enrollment _____

Questions? Problems? Need help?

- Call the WHA Member Services department at **(916) 563-2250, (888) 563-2250** or **TTY (888) 877-5378**.
- Write to us at **Western Health Advantage, 1331 Garden Highway, Suite 100, Sacramento, CA 95833-9773**.
- Send an e-mail message to us at memberservices@westernhealth.com**.**
- Check our web page at www.westernhealth.com.

This Combined Evidence of Coverage and Disclosure Information along with your enrollment application and any additional amendments constitutes the *WHA Care+* plan information. This document will be mailed to you annually at the beginning of the Plan Year.

WHA Care+ does not discriminate in the employment of staff or in the provision of health care services on the basis of race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin. Federal law mandates that the Plan comply with Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, other laws applicable to recipients of federal funds, and all other applicable laws and rules.

Plan Changes for 2003

Please make note of the following changes and/or clarifications to your plan effective January 1, 2003.

- Revised language under "Plan Administration—Continuation of the Plan"
- Revised language under "Plan Administration—-Nondiscrimination Statement"
- Revised language under "Member Rights and Responsibilities"

If you have any questions, please feel free to contact our Member Services Department at (916) 563-2250 or (888) 563-2250, or TTY (888) 877-5378 Monday through Friday between 8 a.m. and 5 p.m.

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Welcome to *WHA Care+*

This document is an explanation of your rights, benefits and responsibilities as a Member of *WHA Care+*, a "Medicare+Choice" (M+C) Plan offered by Western Health Advantage (WHA), a M+C Organization. It also explains our responsibilities to you. Your Member Contract for *WHA Care+* consists of this Combined Evidence of Coverage and Disclosure Information, your individual election form and any current or future amendments.

This Combined Evidence of Coverage and Disclosure Information contain important information. Please read it carefully. Keep it in a safe place, available for quick reference.

WHA Care+ is not an insurance policy that merely pays Medicare deductibles and coinsurance charges (commonly called a "Medigap" or "Medicare supplement" policy). Instead, WHA has entered into a contract with the **Center for Medicare and Medicaid (CMS)**, the federal government agency that administers Medicare. This contract authorizes WHA to arrange for comprehensive health services to persons who are entitled to Medicare benefits and who choose to enroll in *WHA Care+*. *WHA Care+* covers all services and supplies offered by Medicare, plus additional services and supplies not covered by Medicare.

By enrolling in *WHA Care+*, you have made a decision to receive all of your health care from WHA Contracted Medical Providers and facilities. You are also required to follow all WHA plan member rules, such as obtaining referrals and prior authorization where required.

Of course, if you need Emergency Services anywhere in the world, or Urgently Needed Services (generally, outside of the area served by *WHA Care+*), those services will be covered. **However, if you receive services from Non-Contracted Medical Providers without Prior Authorization, except for Emergency Services or Urgently Needed Services, neither WHA nor Medicare will pay for those services.**

How Does *WHA Care+* Work?

The concept behind *WHA Care+* is to reduce health care costs for you and for Medicare. Medicare pays WHA a monthly payment to provide or arrange for your entire Medicare covered services. This payment also covers Medicare deductibles and co-insurance costs which you would pay out-of-pocket under regular fee-for-service Medicare. The payment also pays for the additional benefits WHA provides which are not covered by Medicare.

You will receive all primary and specialty care from doctors in WHA contracted medical groups and other Plan providers, except in unusual circumstances when an authorization is made for specialist physician care outside the medical group or at another hospital, for emergency services anywhere, urgently needed care when out of the service area, or urgently needed care within the service area in the circumstance that the WHA provider network is unavailable or inaccessible.

The WHA provider network will always offer you a wide choice of physicians, but the ongoing availability of any particular physician cannot be guaranteed. Information on the numbers of hospitals and physicians, the kinds of physicians in the WHA network and their locations are presented in the WHA Provider Directory. If you have any questions or need the most current information on a given provider, please contact the Member Services department at (916) 563-2250 or (888) 563-2250.

Maintaining an ongoing relationship with a physician who knows you well and whom you trust is an important part of a good health care program. That's why with *WHA Care+* you are asked to select a Primary Care Physician from our Physician Directory. Most of our Primary Care Physicians have advanced training in internal medicine and family practice.

Once you select a Primary Care Physician, you should contact his or her office to arrange for an initial appointment. Use this initial visit to get acquainted with your new doctor, tell the doctor about any ongoing medical conditions you may have or care you have been receiving, or medications you are taking. Also, talk with your Primary Care Physician about any concerns or questions you may have.

Your Primary Care Physician will see you in his or her office or clinic for periodic health evaluations and other routine appointments, and will coordinate all your medical care. This includes ordering X-rays, laboratory tests, home care, physical and other types of therapy; referring you to specialists; and arranging with the Health Plan for necessary hospitalizations. Members may receive some services without a referral from the Primary Care Physician - these are called **self-referral services**, and include services such as mammograms, annual refractive eye exams, women's routine preventive gynecological services, obstetrical services, and some immunizations.

All medical services performed by health care specialists other than your Primary Care Physician or those specifically designated as self-referral services must have Prior Authorization from your WHA Primary Care Physician, except in case of Emergency Services or Urgently Needed Services (as defined in "Section 1 – Health Care Terms"). If you need help in selecting a Primary Care Physician, you may call us at (916) 563-2250, (888) 563-2250 **or TTY (888) 877-5378**.

Transferring to Another Primary Care Provider or Medical Group

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

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

Exceptions

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

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

NOTE: If you are experiencing one of the above listed exceptions and believe you should be allowed to transfer to another PCP or Medical Group/IPA because of unusual or serious circumstances, please contact WHA's Member Service Department at (916) 563-2250 or (888) 563-2250 and request a review for special consideration to your situation.

Call Our Member Services Department Whenever You Need Information

In addition to arranging comprehensive medical benefits, we strive to provide you with the information you need about *WHA Care+* when you need it. We have specially trained WHA Member Services Representatives you can call when you have questions about:

- Covered Services,
- Making address or phone number changes,
- Primary Care Physician changes,
- Enrollment or Disenrollment,
- Appeal and grievance rights,
- Medical care when you are traveling,
- The care you are receiving, and
- Any other questions or concerns regarding *WHA Care+*.

You can reach the Member Services Department by calling (916) 563-2250, (888) 563-2250 **or TTY (888) 877-5378** between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday.

Updating Your Membership Records

Your *WHA Care+* membership record contains information from your individual election form including your address and telephone number, as well as your specific *WHA Care+* coverage, and the Primary Care Physician you selected upon enrollment. These records are very important because they identify you as an eligible *WHA Care+* Member and determine where you can receive services. Please report any changes in name, address or phone number to the Member Services Department immediately.

You Can Tell Us How We're Doing

Our goal is to arrange the Covered Services you need to stay as healthy and active as you can be. You can play a key role by telling us how we are doing.

From time to time, we will be asking your thoughts on *WHA Care+* through our Member satisfaction surveys. These surveys help us measure the performance of our Contracted Physicians and Medical Providers, as well as the quality of our Member service.

Your responses and comments help identify our strengths as well as areas for needed improvement. Of course, you can call or write to us at any time with helpful comments, questions and observations. Your personal input is always welcome, whether it is concerning something you like about our plan or something you feel is a problem area.

Section 1 - Health Care Terms

The following definitions apply to this Evidence of Coverage and Disclosure Information.

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

Basic Benefits – All healthcare services that are covered under the Medicare Part A and Part B programs (except hospice services), additional services that we use Medicare funds to cover, and other services for which you are required to pay a premium.

Benefit Period – A benefit period is a way of measuring your use of services under Medicare Part A. This is used to determine Medicare coverage, and coverage under *WHA Care+*. A benefit period begins with the first day of a Medicare covered inpatient hospital stay and ends with the close of a period of 60 consecutive calendar days during which you were neither an inpatient of a hospital nor of a skilled nursing facility (SNF). Generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital. The type of care actually received is not relevant. However, you are an inpatient in a SNF only if your care in the SNF meets certain skilled level of care standards. This means that in order to have been an inpatient while in a SNF, you must have required skilled services on a daily basis and received daily skilled services, which could, as a practical matter, only have been provided in a SNF on an inpatient basis.

Calendar Year – A twelve (12) month period that begins on January 1 and ends twelve (12) consecutive months later on December 31.

Center for Health Dispute Resolution (CHDR) – An independent CMS contractor that reviews appeals by members of Medicare managed care plans, including Medicare+Choice plans such as *WHA Care+*.

Center for Medicare and Medicaid Services (CMS) – The federal agency responsible for administering Medicare.

Combined Evidence of Coverage and Disclosure Information – This document, which explains Covered Services and defines our obligations and your rights and responsibilities as a Member of *WHA Care+*.

Complaint – An expression of dissatisfaction by a member or Provider either oral or written, about their experience with WHA, a Medical Group and/or any WHA providers.

Contracted Hospital – A Hospital that has a contract with WHA to provide services and/or supplies to you.

Contracted Medical Group – Physicians organized as a legal entity for the purpose of providing medical care. Our Contracted Medical Groups have an agreement with WHA to provide medical services to Members.

Contracted Medical Provider – A health professional, a supplier of health items, or a health care facility having an agreement with WHA or a Contracted Medical Group to provide or coordinate medical services to Members.

Contracted Pharmacy – A pharmacy that has an agreement with us to provide you with medication(s) prescribed by your Contracted Medical Provider in accordance with *WHA Care+*.

Contracted Physician – A physician that has an agreement with us to provide you with medical care.

Copayment – The fee you pay at the time of receiving medical services as described in "Section 15 - *WHA Care+* Schedule of Medical Benefits".

Covered Services – Those benefits, services and supplies that we must furnish or pay for plan members under *WHA Care+*.

Custodial Care – Care furnished for the purpose of meeting non-Medically Necessary personal needs which could be provided by persons without professional skills or training, such as assistance in mobility, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial Care is not covered by *WHA Care+* or Medicare unless provided in conjunction with Skilled Nursing Care.

Disenroll or Disenrollment – The process of ending your membership in *WHA Care+*.

Durable Medical Equipment – Equipment that can withstand repeated use; is primarily and usually used to serve a medical purpose; is generally not useful to a person in the absence of illness or injury; and is appropriate for use in the home. To be covered, Durable Medical Equipment must be Medically Necessary and prescribed by a Contracted Medical Provider for use in your home. Examples could include oxygen equipment, wheelchairs, hospital beds and other items that are determined Medically Necessary, in accordance with Medicare law, regulations and guidelines.

Effective Date - The date your *WHA Care+* coverage begins.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 1) serious danger to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; 2) serious damage to bodily functions; or 3) serious dysfunction of any bodily organ or part, including psychiatric dysfunction.

Emergency Services – Covered Services (inpatient or outpatient) that are 1) furnished by a provider qualified to furnish such services; and 2) needed to evaluate or stabilize an Emergency Medical Condition.

Emergency Services and Care also pertain to:

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

WHA will make all final determinations about Emergency care.

Exclusion – Items or services, which are not covered under this Combined Evidence of Coverage and Disclosure Information.

Experimental or Investigational Procedures – Services, tests, treatments, supplies, devices or drugs which WHA determines are not accepted as standard medical practice by informed medical professionals in the United States, at the time the services, tests, treatments, supplies, devices or drugs are rendered, as safe and effective in treating or diagnosing the condition for which their use is proposed. WHA will use its own policies and Medicare guidelines to determine whether a service or item is experimental. Experimental or Investigational Procedures or items are not covered under this plan.

Fee-for-Service Medicare – A payment system by which doctors, hospitals and other providers are paid for each service performed (also known as traditional and/or original Medicare).

Grievance – A term commonly used to describe requests for the health plan to change a decision. Grievance is a stage in the appeals process.

Group Agreement – The Group Service Agreement between the employer and WHA.

Home Health Agency – A Medicare-certified agency which provides intermittent Skilled Nursing Care and other therapeutic services in your home when Medically Necessary,
when you are confined to your home and when authorized by your Primary Care Physician.

Hospice – An organization or agency, certified by Medicare, which is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Hospital – A Medicare-certified institution licensed by the State, which provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term "Hospital" does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily Custodial Care, including training in routines of daily living.

Independent Physicians Association (IPA) – A group of physicians who function as a Contracted Medical Provider/Group yet work out of their own independent medical offices.

Life-Threatening – means either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease~~,~~ is interrupted.

- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention or treatment is survival.

Lock-In Feature – An arrangement under which all Covered Services, with the exception of Emergency Services or Urgently Needed Services, must be provided or authorized by your Contracted Medical Provider or your Primary Care Physician. If you receive services from a Non-Contracted Medical Provider without Prior Authorization, except for Emergency Services or Urgently Needed Services, neither WHA nor Medicare will pay for that care.

Medical Director – A licensed physician who is an employee of or under contract with WHA, and is responsible for the overall quality of the medical care we provide.

Medically Necessary – Medical Services or Hospital Services, which are determined by WHA to be:

(a) Rendered for the treatment or diagnosis of an injury or illness; and

(b) Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; and

(c) Not furnished primarily for the convenience of the Member, the attending physician, or other Provider of service; and

(d) Furnished in the most economically efficient manner, which may be provided safely and effectively to the Member.

Whether there is "sufficient scientific evidence" shall be determined by WHA based upon the following: peer reviewed medical literature; publications, reports, evaluations and regulations issued by state and federal government agencies, Medicare local carriers and intermediaries; and such other authoritative medical sources as deemed necessary by WHA.

Medicare – The federal government health insurance program established by Title XVIII of the Social Security Act.

Medicare Part A – Hospital insurance benefits including inpatient Hospital care, Skilled Nursing Facility care, Home Health Agency care and Hospice care offered through Medicare.

Medicare Part B – Supplementary medical insurance that is optional and requires a monthly premium. Part B covers physician services (in both Hospital and non-hospital settings) and services furnished by certain non-physician practitioners. Other Part B services include lab testing, Durable Medical Equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services, and blood not covered under Medicare Part A.

M+C Organization – A public or private entity organized and licensed by the State as a risk-bearing entity that is certified by CMS as meeting Medicare+Choice (M+C) requirements. M+C Organizations can offer one or more M+C Plans. Western Health Advantage is a M+C Organization.

M+C Plan – A policy or contract offered by a Medicare+Choice (M+C) Organization under which a specific set of health benefits is offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area covered by the Plan. *WHA Care+* is a M+C plan.

Member – You, the Medicare beneficiary entitled to receive Covered Services, who has voluntarily elected to enroll in *WHA Care+* and whose enrollment has been confirmed by CMS.

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

- A "Complaint" is an expression of dissatisfaction by a member or Provider either oral or written, about their experience with WHA, a Medical Group and/or any WHA providers.
- An "Appeal" is a formal request by a practitioner or member for reconsideration of a decision,

such as a utilization review recommendation, a benefit payment, an administrative action, or a quality-of-care or service issue, with the goal of finding a mutually acceptable solution.

- A "Grievance" is a term commonly used to describe requests for the health plan to change a decision. Grievance is a stage in the appeals process.

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

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

Non-Contracted Medical Provider or Facility – Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the State or Medicare to deliver or furnish health care services, who is neither employed, owned, operated by, nor under contract with WHA to deliver Covered Services to you.

Office Visit – A visit to your Primary Care Physician, Specialist, other Contracted Medical Provider or Non-Contracted Medical Provider upon Referral.

Open Enrollment – A designated period of time in which you may Disenroll from *WHA Care+* and enroll in any other Medicare+Choice (M+C) Plan or elect to change your enrollment from a M+C Plan to original Medicare. Beneficiaries in original Medicare or any other M+C Plan can also enroll in any M+C Plan during an open enrollment period.

Part A Premium – Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers and by part of the self-employment tax paid by self-employed persons. If you are entitled to benefits under either the Social Security or Railroad Retirement systems or worked long enough in federal, state, or local government employment to be insured under Part A, you do not have to pay a monthly premium. If you do not qualify for premium-free Part A benefits, you may buy the coverage if you are at least 65 years old and meet certain requirements. You may also buy Part A if you are under age 65 and are entitled to Medicare under the disability provisions.

Part B Premium – A monthly premium paid to Medicare (usually deducted from your Social Security check) to cover Part B services. You must continue to pay this premium to Medicare to receive Covered Services under *WHA Care+*.

Peer Review Organization (PRO) – An independent contractor paid by CMS to review Medical Necessity, appropriateness and quality of medical care and services provided to Medicare beneficiaries. Upon request, the PRO also reviews Hospital discharges for appropriateness and quality of care complaints.

Plan Premium – The monthly payment to *WHA Care+*, along with the Part B Premiums paid to Medicare that entitles you to the Covered Services outlined in this Combined Evidence of Coverage and Disclosure Information.

Preferred Drug List (Formulary) – A continually updated list of prescription medications, which represent the current clinical judgment of the members of *WHA Care+* 's Pharmacy and Therapeutics Committee as safe and effective medications. This committee is comprised of physicians and pharmacists, many of which are Providers and experts in the diagnosis and treatment of disease. The Preferred Drug List contains both brand name drugs and generic drugs, all of which have FDA (Food and Drug Administration) approval.

Prescription Benefit Manager – A firm that contracts with health plans to manage pharmacy services.

Prescription Unit – The maximum amount (quantity) of medication that may be dispensed per prescription for a single Copayment. For most oral medications, the Prescription Unit represents a thirty (30) day supply of medication. The Prescription Unit for other medications will represent a single container, inhaler unit, package, or course of therapy. For drugs that could be habit-forming, the Prescription Unit is set at a smaller quantity for your protection and safety.

Primary Care Physician – The *WHA Care+* contracted physician you choose to provide most of your routine care. Your Primary Care Physician is responsible for providing or authorizing Covered Services while you are a Member of *WHA Care+*. Primary Care Physicians may be physicians of internal medicine, family practice, general practice, pediatricians, or, in some instances, obstetricians/gynecologists.

Prior Authorization – A system whereby a Provider must receive approval from *WHA Care+*, a Contracted Medical Group or a Contracted Physician before you receive certain health care services.

Provider – Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the State or Medicare to deliver or furnish health care services.

Referral – A formal recommendation by your Primary Care Physician or Contracted Medical Group that you receive care from a Specialist, Contracted Medical Provider or Non-Contracted Medical Provider.

Seriously Debilitating – Diseases or conditions that cause major irreversible morbidity or sickness.

Service Area – A geographic area approved by CMS within which a Medicare+Choice eligible individual must reside in order to enroll in *WHA Care+*.

Skilled Nursing Care – Services that can only be performed by or under the supervision of licensed nursing personnel.

Skilled Nursing Facility – A facility, which provides inpatient Skilled Nursing Care, rehabilitation services or other related health services and is certified by Medicare. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily Custodial Care, including training in routines of daily living.

Specialist – Any duly licensed physician, osteopath, psychologist or other practitioner (as defined by Medicare) that your Primary Care Physician may refer you to. Also any duly licensed emergency room physician who provides Emergency Services to you.

State – The State of California, which is responsible for licensing and regulating managed care organizations like WHA.

Time-Sensitive – A situation where waiting for a standard decision could seriously jeopardize your life or health, or your ability to regain maximum function.

Urgently Needed Services – Covered Services provided when you are temporarily absent from the *WHA Care+* Service Area (or, under unusual circumstances, provided when you are in the Service Area but the *WHA Care+* provider network is temporarily unavailable or inaccessible) when such services are Medically Necessary and immediately required as a result of an 1) unforeseen illness, injury, or condition; and 2) it is not reasonable given the circumstances to obtain the services through *WHA Care+*.

Utilization Review – A process used by WHA and its Contracted Medical Groups to promote the efficient use of resources and the quality of health care. Utilization review includes prospective, concurrent and retrospective review of medical services.

WHA Member Services – A department of WHA dedicated to answering your questions concerning your membership, benefits, grievances and appeals. A WHA Member Services representative is available to assist you during regular business hours (Monday through Friday, 8:00 a.m. to 5:00 p.m.) by calling (916) 563-2250, (888) 563-2250 or **TTY (888) 877-5378** or by writing to: *WHA Care+*, Attn: Member Services, 1331 Garden Highway, Suite 100, Sacramento, CA 95833-9773.

***WHA Care+* Provider Directory** - The provider directory lists all of the network Primary Care Physicians and specialists approved for referrals by your Primary Care Physician. Any provider not listed in WHA's provider directory is a non-Participating Provider and you must obtain Prior Authorization from WHA or your Primary Care Physician before obtaining services.

Section 2 - Eligibility, Enrollment, Termination and Plan Administration Provisions

Who is Eligible to Enroll in *WHA Care+*

A Medicare beneficiary generally is eligible to enroll in *WHA Care+* if he or she is entitled to Medicare Part A (see definition in "Section 1- Health Care Terms") and enrolled in Medicare Part B (see definition in "Section 1 - Health Care Terms").

A Medicare beneficiary is not eligible to enroll in *WHA Care+* if he or she has end-stage renal disease (ESRD). ESRD is permanent kidney failure, which requires regular kidney dialysis or a transplant to

maintain life. If an individual was already enrolled with WHA when he or she developed ESRD, he or she can remain as an enrollee of WHA in *WHA Care+*. If you are a *WHA Care+* enrollee who developed ESRD while enrolled with WHA, you cannot be Disenrolled from *WHA Care+* for health reasons.

Permanent residence in the *WHA Care+* Service Area, as described in "Section 14 – *WHA Care+* Service Area" is also a condition for enrollment in *WHA Care+*.

You must complete and sign an individual election form to enroll in *WHA Care+*. If another person assists in the completion of the individual election form, that person must also sign.

Individuals who have enrolled in *WHA Care+* agree to abide by the Plan rules.

Individuals who meet the above eligibility requirements cannot be denied membership in *WHA Care+* on the basis of health status.

When Your *WHA Care+* Coverage Begins

Generally, coverage with *WHA Care+* begins on the first day of the month following the date a signed individual election form is received by WHA, provided all entitlement requirements have been met. Enrollments received during open enrollment are effective on January 1. From the Effective Date forward, all Covered Services must be received from WHA Contracted Medical Providers, except for Emergency Services, Urgently Needed Services, or Covered Services for which Prior Authorization has been obtained. **If a *WHA Care+* member receives services from Non-Contracted Medical Providers without Prior Authorization, except for Emergency Services or Urgently Needed Services, neither *WHA Care+* nor Medicare will pay for those services.**

A Note about Medicare Supplement (Medigap) Policies

You may consider canceling any Medicare supplement (Medigap) policy you have after *WHA Care+* has sent you written confirmation of your enrollment in the Plan. However, if you later Disenroll from *WHA Care+*, you may not be able to have your Medigap policy reinstated.

Note: In certain cases you can be guaranteed issue (without medical underwriting or pre-existing condition exclusions) of a Medigap policy. Examples of these cases include the following:

- You are Disenrolled from *WHA Care+* for a reason that does not involve any fault on your part (e.g., you move out of the *WHA Care+* Service Area or the *WHA Care+* contract with CMS terminates);
- You enrolled in *WHA Care+* upon first reaching Medicare eligibility at age 65, but Disenroll from *WHA Care+* within 12 months of your effective date.
- Your supplemental coverage under an employee welfare benefit plan terminates;
- Your enrollment in a Medigap policy ceases because of the bankruptcy or insolvency of the insurer issuing the policy, or because of other involuntary termination of coverage for which there is no State law provision relating to continuation of coverage; or
- You were previously enrolled under a Medigap policy and terminated your enrollment to participate, for the first time, in *WHA Care+* and you Disenroll during the first 12 months.

You must apply for a Medigap policy within 63 calendar days after your *WHA Care+* coverage terminates and submit evidence of the date of your loss of coverage. Please call the WHA Member Services department for additional information regarding guaranteed Medicare supplemental policies.

Should you choose to keep your Medicare supplement (Medigap) policy, you may not be reimbursed for services you receive. Most supplemental (Medigap) policies will not pay for any portion of such services because:

- Supplemental insurers (Medigap insurers) process their claims based on proof of an Original Medicare payment, usually in the form of an Explanation of Medicare Benefits (EOMB). However, as long as you are a Member of *WHA Care+*, Original Medicare will not process any claims for medical services you receive.

- *WHA Care+* has the financial responsibility for all Medicare-covered health services you need as long as you follow *WHA Care+'s* procedures on how to receive medical services.

Becoming and Remaining a Member of *WHA Care+*

Who Is Eligible

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

The following individuals are eligible to enroll in this Plan. If the Plan is a Health Maintenance Organization (HMO), 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 + Choice Managed Care contract is not eligible for this plan.

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. 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)."

*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 average.

Annuitant (including Survivor Annuitant):

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

Survivor Annuitant – A deceased Employee's or Annuitant's family member receiving monthly benefits from a University-sponsored defined benefit plan.

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

If you are eligible for Medicare, see "Effect of Medicare on Annuitant 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 reserve the right to periodically request documentation to verify eligibility of Family Members. Documentation could include a marriage certificate, birth certificate(s), adoption records, or other official documentation. In addition, you will be asked to submit a copy annually of your Federal income tax return (IRS form 1040 or IRS equivalent showing the covered dependent Family Member and your signature) to the University to verify income tax dependency for those categories where it is a condition of eligibility.

Spouse: Your legal spouse. (Note: if you are a Survivor Annuitant, you may not enroll 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 dependent on you for at least 50% of his or her support and is your dependent for income tax purposes, 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 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 an adult dependent relative or same-sex domestic partner (and the same-sex domestic partner's children/grandchildren) as set forth in the University of California Group Insurance Regulations. 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, an Annuitant, a Survivor Annuitant or a Family Member, but not under any combination of these. If both husband and wife are 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 coverage but not under both.

ENROLLMENT

For information about enrolling yourself or an eligible Family Member, see the person at your location who handles benefits. If you are an Annuitant, contact the University's Customer Service Center. Enrollment transactions may be by paper form or electronic, 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. Survivor Annuitants may not add Spouses to their coverage.

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 and you move or are transferred out of that HMO's service area, or will be away from the HMO'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 HMO's service area.

At Other Times

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

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

If you have two or more Family Members enrolled in the Plan, you may add a newly eligible Family Member at any time. See "Effective Date".

If you are an Annuitant, 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 before the effective date of retirement (or the date disability or survivor benefits begin).

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 an Annuitant 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.

When you already have two or more Family Members enrolled and enroll another Family Member, coverage may be retroactive with the effective date limited to the later of:

a) the date the newly added Family Member becomes eligible, or

b) a maximum of 60 days prior to the date his or her enrollment transaction is completed.

Change in Coverage

In order to change from individual to two-party coverage and from two-party to family coverage, or to add another Family Member to existing family coverage, contact the person who handles benefits at your location (or the University's Customer Service Center if you are an Annuitant).

Effect of Medicare on Annuitant Enrollment

If you are an Annuitant 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.

Annuitants and their Family Members who are eligible for premium free Medicare Part A, but decline to enroll in Part B of Medicare, will be assessed a monthly offset fee by the University to cover increased costs. Annuitants or Family Members who are not eligible for part A will not be assessed an offset fee. A notarized affidavit attesting to their ineligibility for Medicare Part A will be required.

Affidavits may be obtained from the University's Customer Service Center. (Annuitants/Family Members who are not entitled to Social Security and 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. 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 the Annuitant Insurance unit at Office of the President.

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 an Annuitant 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 an Annuitant or Survivor Annuitant 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 an Annuitant).

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 18 months. If a Subscriber commits fraud or deception, the Subscriber and any Family Members will be deenrolled for 18 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.

Exception to Cancellation of Group Benefits

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

- You or any of your enrolled Family Members are a registered bed patient in a hospital at the date of termination. You or your Family Members will continue to receive all benefits of coverage for the condition confining you to the hospital, subject to the fees and applicable Copayments until those benefits expire or you are discharged from the hospital, whichever occurs first.
- You or any of your enrolled Family Members are receiving inpatient obstetrical care at the date of termination and there has been no default in fees. Inpatient obstetrical care will continue only through discharge.
- Total disability by a condition for which you are receiving covered benefits. WHA will continue to maintain coverage for the disabling condition only. Coverage will end (1) at the close of the 12th month following termination, (2) when it is determined you are no longer disabled, or (3) the disabled person is covered under a replacement agreement or policy without limitations as to the disability condition, whichever occurs first.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABLITY ACT (HIPAA)

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

If subscribers or dependents have questions concerning HIPAA, they can contact CMS at (415) 744-3600 or at the following internet address:

http://www.hcfa.gov/medlearn/hipaa.htm

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

OPTIONAL CONTINUATION OF COVERAGE

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

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 94612-3557
(800) 888-8267

Annuitants 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 Highway, Suite 100
Sacramento, CA 95833
916-888-563-2250
TTY (888) 877-5378

Group Contract Number

The Group Contract Number for this Plan is: 00-1121

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, annuitants and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, premiums and what portion of the premiums the University will pay. The portion of the premiums that the University pays is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation.

Financial Arrangements

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

Agent for Serving of Legal Process

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

Your Rights Under the Plan

As a participant in a University of California medical plan, you are entitled to certain rights and protections.

All Plan participants shall be entitled to:

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

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

Claims Under the Plan

To file a claim or to appeal a denied claim, refer to Section 9 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 Mattie Williams, University of California, Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Executive Director Sheila O'Rourke, University of California, Office of the President, 1111 Franklin Street, Oakland, Ca 94607.

SECTION 3 - *WHA CARE+* MEMBER RIGHTS AND RESPONSIBILITIES

Your Rights

As a *WHA Care+* Member, you have the ***right*** to:

1. Timely, Quality Care

- Choice of a qualified Primary Care Physician and Contracted Hospital. (Note: Selection choice may be limited by the provider's patient caseload.)

- Candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.

- Timely access to your Primary Care Physician and Referrals to Specialists when Medically Necessary.

- Receive Emergency Services when you, as a prudent layperson acting reasonably, believe that an Emergency Medical Condition exists. In such cases, services will not be withheld pending review of your claim.

- Actively participate in decisions regarding your own health and treatment options.

- Receive Urgently Needed Services when traveling outside the Plan's service area or in the Plan's service area when unusual or extenuating circumstances prevent you from obtaining care from your Primary Care Physician.

2. Treatment with Dignity and Respect

- Be treated with dignity and respect and to have your right to privacy recognized.

- Exercise these rights regardless of your race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion or your national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for your care. Expect these rights will be upheld by both the Plan and contracted providers.

- Confidential treatment of all communications and records pertaining to your care. To have access to personal medical records. Written permission from you or your authorized representative shall be obtained before medical records can be made available to any person not directly concerned with your care or responsible for making payments for the cost of such care.

- Extend your rights to any person who may have legal responsibility to make decisions on your behalf regarding your medical care.

- Refuse treatment or leave a medical facility, even against the advice of physicians (providing you accept the responsibility and consequences of the decision).

- Complete an Advance Directive, living will or other directive to your Contracted Medical Providers.

3. *WHA Care+* Information

- Information about *WHA Care+* and Covered Services.

- Know the names and qualifications of physicians and health care professionals involved in your medical treatment.

- Receive information about an illness, the course of treatment and prospects for recovery in terms you can understand.

- Information regarding how medical treatment decisions are made by Contracted Medical Groups or *WHA Care+*, including payment structure.

- Information about your medications - what they are, how to take them and possible side effects.

- Receive as much information about any proposed treatment or procedure as you may need in order to give your informed consent or to refuse a course of treatment. Except in cases of Emergency Services, this information shall include a description of the procedure or treatment description, the medically significant risks involved, any alternate course of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.

- Reasonable continuity of care and to know in advance the time and location of an appointment, as well as the name of the physician providing care.

- Be advised if a physician proposes to engage in experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.

- Be informed of continuing health care requirements following discharge from inpatient or outpatient facilities.

- Examine and receive an explanation of any bills for non-Covered Services, regardless of payment source.

4. Timely Problem Resolution

- Make complaints and appeals without discrimination and expect problems to be fairly examined and appropriately addressed.

- Responsiveness to reasonable requests made for services.

Your Responsibilities

As a Member of *WHA Care+*, you have the ***responsibility*** to:

- Provide your physicians or other health care Providers the information needed in order to care for you.

- Do your part to improve your own health condition by following treatment plans, instructions and care that you have agreed on with your physician(s).

- Behave in a manner that supports the care provided to other patients and the general functioning of the facility.

- Accept the financial responsibility associated with services received while under the care of a physician or while a patient at a facility.

- Review information regarding Covered Services, policies and procedures as stated in your Combined Evidence of Coverage and Disclosure Information.

- Ask questions of your Primary Care Physician or *WHA Care+*. If you have a suggestion, concern, or a payment issue, we recommend you call the WHA Member Services department.

SECTION 4 - HOW YOUR *WHA CARE+* COVERAGE WORKS

Your *WHA Care+* Membership Card

Your *WHA Care+* Membership Card contains important information about you as a Member of *WHA Care+*. In nearly all instances, you will need to present your membership card to your health care Provider to verify your coverage and/or obtain services covered by *WHA Care+.* Carry your *WHA Care+* membership card with you at all times.

Although you never need to give up your Medicare card, you must now use only your *WHA Care+* card to receive all services covered by WHA. It is important that you use only your *WHA Care+* membership card - **NOT** your Medicare card - for these reasons:

1. To prevent you from receiving medical services from Non-Contracted Medical Providers in error,

2. In the case of an Emergency Medical Condition, to alert hospital staff of the need to notify your Primary Care Physician or *WHA Care+* as soon as possible so that *WHA Care+* is involved in the management of your care, and

3. To prevent errors in billing. *WHA Care+* pays the bills on behalf of Medicare. Medicare will not pay the bills while you are a Member of *WHA Care+*.

If you lose your membership card or move, please contact the WHA Member Services Department.

How the Lock-In Feature Works for You

As a *WHA Care+* Member, all your medical benefits (except for Emergency Services, Urgently Needed Services, and self-referral services) are provided and arranged by your Primary Care Physician, a personal physician you choose from our list of Contracted Medical Providers. You are "Locked-In" to this Provider who will provide and coordinate all your routine health care services.

The "Lock-In" feature is key to you and *WHA Care+*. WHA is able to offer you this Plan because of our contract with the Center for Medicare and Medicaid Services (CMS), the government agency that oversees Medicare. Under this contract, the federal government agrees to pay us a fixed monthly dollar amount for each Member we serve. We use the monthly amount received from the federal government to contract with WHA medical groups, Hospitals and other health care Providers to arrange care for you.

WHA Care+ is affordable because of the "Lock-In" feature and is one of the reasons why WHA can arrange additional services not covered by Medicare.

If you receive services from Non-Contracted Medical Providers without Prior Authorization, except for Emergency Services or Urgently Needed Services, neither WHA nor Medicare will pay for those services.

SECTION 5 - WORKING WITH YOUR CONTRACTED MEDICAL PROVIDERS

Your Primary Care Physician

Your relationship with your Primary Care Physician is an important one. That's why we strongly recommend you choose a Primary Care Physician close to your home. Having your Primary Care Physician nearby makes receiving medical care and developing a trusting and open relationship that much easier.

Once you have chosen your Primary Care Physician, we recommend that you have all your medical records transferred to his or her office. This will give your Primary Care Physician access to your medical history, and make him or her aware of any existing health conditions you may have.

Always ask to see your Primary Care Physician when you make an appointment. Your Primary Care Physician is now responsible for all your routine health care services, so he or she should be the first one you call with any health concerns.

You Can Change Primary Care Physicians

If you wish, you may request to change your Primary Care Physician at any time. Your request will be effective on the first day of the month following the receipt of your request. You will also receive a replacement Plan membership card with the name of your new physician. Please call WHA Member Services for assistance.

Should a contracted plan health care provider terminate his or her contract with WHA and the termination affects you, we will make every effort to notify you within 15 calendar days. We will assist you in selecting a new primary care provider or making sure you have access to all provider services in the Plan's benefit package.

How to Schedule an Appointment with your Primary Care Physician

It's easy – simply call your Primary Care Physician's office and request an appointment. There are no special rules to follow. Appointments are scheduled according to the type of medical care you are requesting. Medical conditions requiring more immediate attention are scheduled sooner.

The telephone number for your Primary Care Physician is listed on your membership card. If at all possible, please call your Primary Care Physician 24 hours in advance if you are unable to make it to a scheduled appointment.

How to Receive Covered Services from a Specialist

Even though your Primary Care Physician is trained to handle the majority of common health needs, there may be a time when he or she feels you need more specialized treatment. In that case, you may receive a Referral to an appropriate Specialist. In some cases, the Referral request will need to have Prior Authorization from WHA.

In order to expand the choice of specialists, WHA has implemented a unique program, the ***Advantage Referral Program***, which allows you to access all specialists in our network rather than just those who have a direct relationship with your Primary Care Physician. If your Primary Care Physician determines that your medical condition requires specialty care, you will be referred to an appropriate provider. You may, however, request to be referred to any of the WHA network specialists. Self-referred annual well-woman exams, obstetrical services and annual eye exams are also included in the Advantage Referral Program and do not require a Primary Care Physician 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 Provider Directory lists all of the network specialists approved for referrals by your Primary Care Physician. Any provider not listed in *WHA Care+'s* Provider Directory is a non-Contracted Medical Provider and you must obtain Prior Authorization from WHA or your Primary Care Physician before obtaining services.

WHA Care+ has also approved procedures to identify, assess, and establish treatment plans, including direct access visits to specialists for members with complex or serious medical conditions. Ask your Primary Care Physician if you have a serious, chronic medical condition that may require you to have direct access to a participating Specialist. In addition, WHA *Care+* has procedures to ensure that members are informed of health care needs that require follow-up and receive training in self-care and other measures to promote their own health.

Second Opinions

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

All requests for second medical opinions should be directed to your Primary Care Physician. You may also contact WHA's Member Services Department at (916) 563-2250 or (888) 563-2250 for assistance or for additional information regarding second opinion procedures.

Hospitalization, Home Health Care, Skilled Nursing Care & Hospice

If your Primary Care Physician or Specialist determines that you require hospitalization, home health care, Skilled Nursing Care or Hospice, he or she will arrange these Covered

Services for you. Please see "Section 15 – *WHA Care+* Schedule of Medical Benefits" for further details.

Hospice services in a Medicare-participating Hospice are not paid for by WHA, but are reimbursed directly by Medicare when you enroll in a Medicare-certified Hospice. We will refer you to a Medicare-participating Hospice if you wish to elect such coverage. Please call the WHA Member Services department at (916) 563-2250 or (888) 563-2250 to obtain this information.

Receiving Care After Hours

If you need to talk to or see your Primary Care Physician after his or her office has closed for the day, call the doctor's office and leave a message asking him or her to call you back. Your doctor or the physician on call will return your call and advise you on how to proceed.

For emergencies or urgent situations, please see "Section 6 – Emergency and Urgently Needed Services" below.

SECTION 6 - EMERGENCY AND URGENTLY NEEDED SERVICES

Emergency Services

Prior Authorization for treatment of Emergency Medical Conditions is not required.

In the event of an Emergency Medical Condition, go to the closest emergency room or to the nearest Contracted Hospital, or call 911 for assistance. *WHA Care+* will cover Emergency Services whether you are in or out of the Service Area. You should have someone telephone WHA or your Contracted Medical Group at the number listed on your membership card as soon as reasonably possible.

Emergency Services are Covered Services (inpatient or outpatient) that are:

1. **furnished by a Provider qualified to furnish such services; and**
2. **needed to evaluate or stabilize an Emergency Medical Condition.**

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

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

Emergency Services and Care also pertain to:

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

It is important to notify WHA of an Emergency Medical Condition so that we can be involved in the management of your health care and transfer can be arranged when your medical condition is stable (depending on the distance involved). Please contact your Primary Care Physician or call the WHA Member Services department at (916) 563-2250 or (888) 563-2250 within forty-eight (48) hours or as soon as reasonably possible.

If you have an Emergency Medical Condition while out of the Service Area, we prefer that you return to the Service Area to receive follow-up care through your Primary Care Physician. However, follow-up care will be covered out of the Service Area as long as the care required continues to meet the definition for either Emergency Services or Urgently Needed Services (see the definition below).

If you have an Emergency Medical Condition within the Service Area, you must receive any follow-up care through your Primary Care Physician.

Post-Stabilization Care

WHA Care+ also provides coverage if you require Medically Necessary, non-Emergency Services needed to ensure that you remain stabilized from the time a Non-Contracted Medical Provider or Facility requests authorization from WHA until:

- you are discharged;
- a Contracted Medical Provider arrives and assumes responsibility for your care; or
- the Non-Contracted Medical Provider and WHA agree to other arrangements.

Urgently Needed Services

WHA Care+ will also cover Urgently Needed Services.

Urgent Care and Emergency Care

Urgent Care: When an Urgent Care situation arises while you are in WHA's Service Area call your Primary Care Physician. You can call your doctor at any time of the day, including evenings and weekends. Explain your condition to your doctor or the Physician on-call and they will direct your care. (See Definitions for Urgent Care).

Emergency Care: If you are in an emergency situation, please call "911" or go to the nearest hospital emergency room. Notify your Primary Care Physician the next business day or as soon as possible. (See Definitions for Emergency Care).

Urgently Needed Services are Covered Services provided when you are temporarily* absent from *WHA Care+'s* Service Area (or under unusual circumstances provided you are in the Service Area but the Plan's contracted provider network is temporarily unavailable or inaccessible) when:

- such services are Medically Necessary and immediately required as a result of an unforeseen illness, injury, or condition; and
- it is not reasonable given the circumstances to obtain the services through the Plan's contracted provider network.

*A temporary absence is an absence from the Service Area lasting not more than 12 months.

If such a medical need arises, we request that, if possible, you first telephone your Primary Care Physician or *WHA Care+,* then seek care from a local doctor. Should this be difficult, you may seek care from local doctors or other medical facilities.

If you must visit a Hospital for Urgently Needed Services when outside the Service Area, you should contact WHA within forty-eight (48) hours or as soon as reasonably possible, so that we can be involved in the management of your care. While we prefer that you return to the Service Area and receive follow-up care through your Primary Care Physician, follow-up care will be covered out of the Service Area when the care required continues to meet the above definition of Urgently Needed Services. **Remember, if you receive services from Non-Contracted Medical Providers without Prior Authorization, except for Emergency Services or Urgently Needed Services, neither *WHA Care+* nor Medicare will pay for those services.**

Refunds for Emergency or Urgently Needed Services Paid by Member

Providers should submit bills to WHA for payment. However, if you paid for any Emergency Services or Urgently Needed Services obtained from Non-Contracted Medical Providers, you should submit your bills to WHA for a payment determination. Requests must be submitted for reimbursement within 180 days of the date services were rendered. Bills should be submitted to the following address:

WHA Care+
Attn: Member Services
1331 Garden Highway, Suite 100
Sacramento, CA 95833-9773

If you have questions about any bills, contact the WHA Member Services department at (916) 563-2250 or (888) 563-2250 TTY (888) 877-5378.

Right to Appeal

We provide you with a written notice every time a service or payment is denied. If WHA or a Contracted Medical Group has denied payment for services you think should have been covered, or if we refuse to arrange for services that you believe are covered by Medicare, you have the right to appeal. See "Section 9 – Appeal and Grievance Procedures".

SECTION 7 - PREMIUMS & PAYMENTS

Your Financial Obligations

As a Member of *WHA Care+,* you have the following financial obligations:

- **All Copayments** shall be paid at the time of service. Specific Copayment amounts are listed in "Section 15 – *WHA Care+* Schedule of Medical Benefits".

- **Medicare Part B Premium.** As a *WHA Care+* Member you must continue to pay your Medicare Part B Premium. If you receive a Social Security annuity check, this premium is automatically deducted from your check. Otherwise your Premium is paid directly to Medicare by you or someone on your behalf (such as your State Medicaid agency).

- **Plan Premiums.** You or your employer group are responsible for paying the monthly *WHA Care+* Premium. WHA has the right to Disenroll you for failure to pay Plan Premiums.

Maximum Copayment Liability

Maximum Copayment liability for Members under this Plan, per calendar year, is limited to $1,000 for an individual and $3,000 for a family of two or more.

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

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

Nonpayment of *WHA Care+* Premiums will automatically return you to Original Medicare. Until you are notified of your Disenrollment, you will still be a *WHA Care+* Member and must continue to use Contracted Medical Providers.

For further details on Disenrollment, please see "Section 8 – Disenrollment from *WHA Care+*".

Changes in Plan Premiums or Benefits

Increases in any Plan Premiums and/or decreases in the level of coverage are permitted only at the beginning of each contract year and must be approved by CMS. Benefits may not change during the contract year. Your employer will receive written notice at least two-hundred ten (210) calendar days prior to the date when such change shall become effective.

SECTION 8 - DISENROLLMENT FROM *WHA CARE+*

Voluntary Disenrollment

You may choose to end your membership in *WHA Care+* for any reason. If you wish to disenroll, request a disenrollment form from WHA's Member Services department. Complete the form and

send it to the WHA Member Services department. We will send you a copy of your written request to disenroll.

If you disenroll at any other time, your disenrollment effective date will be determined by the date your written request is received by us. If we receive your request before the 10th day of the month, your termination date will be the first day of the following month.

If we receive your request after the 10th day of the month, your termination date will be the first day of the second month. For example, if we receive your request on August 14th, your termination date would be October 1. Disenrollments during open enrollment will be effective on the following January 1. We will send you a letter confirming your disenrollment date, once we receive approval from CMS.

You may also disenroll through any Social Security Administration office, or a Railroad Retirement Board office if you are a railroad annuitant.

Even though you have requested Disenrollment, you must continue to receive all covered services from *WHA Care+* Contracted Medical Providers until the date your Disenrollment is effective.

Original Medicare will cover you after you Disenroll from *WHA Care+* unless you have joined another Medicare+Choice Plan.

Moves or Extended Absences from the *WHA Care+* Service Area

If you are permanently moving out of the *WHA Care+* Service Area, or plan an extended absence, it is important to notify us of the move or extended absence before you leave the Service Area.

Failure to notify WHA of a permanent move or an extended absence may result in your involuntary Disenrollment from *WHA Care+,* since we are required to Disenroll you if you have moved out of the service area for more than 6 months. If you remain enrolled after a move or extended absence (and have not been involuntarily Disenrolled as just described), you should be aware that services will not be covered unless they are received from a *WHA Care+* provider in the *WHA Care+* Service area (except for Emergency Services, Urgently Needed Services and Prior Authorized Referrals).

Fraud

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

Involuntary Disenrollment

WHA may Disenroll you from *WHA Care+* only under the conditions listed below. You will not be Disenrolled due to your health status.

1. If you move permanently out of the Service Area and do not voluntarily Disenroll[A,C];

2. If your entitlement to Medicare Part A or Part B benefits ends;

3. If you supply fraudulent information or make misrepresentations on your individual election form which materially affects your eligibility to enroll in *WHA Care+* [A,B,C];

4. If you are disruptive, unruly, abusive or uncooperative to the extent that your membership in *WHA Care+* seriously impairs our ability to arrange Covered Services for you or other individuals enrolled in the plan. Involuntary Disenrollment on this basis is subject to prior approval by CMS[A,C];

5. You enroll an ineligible individual;

6. You allow another person to use your *WHA Care+* membership card to obtain Covered Services [A,B,C];

7. You or your employer fail to pay the Plan Premiums; or

8. The contract between WHA and CMS under which *WHA Care+* is offered is terminated[D], or *WHA Care+* ś service area is reduced.[C]

[A] An involuntary Disenrollment on these grounds is subject to the WHA grievance procedures;

[B] Requires a referral to the Inspector General of the Federal Department of Health and Human Services and may result in criminal prosecution;

[C] Disenrollment on these grounds can only occur after you have been provided notice with an explanation of the reasons for the Disenrollment and information on WHA applicable grievance rights. CMS must also be notified.

[D] The contract with CMS is renewed on an annual basis. At the end of each contract year, either the Medicare+Choice (M+C) Organization or Medicare can end the contract. If the M+C Organization ended the contract, you would receive a minimum ninety (90) day notification before the end of the contract. If CMS ended the contract you would receive a minimum thirty (30) day notification. We would explain what your options are at that time. For example, there may be other M+C Plans in the area for you to join, if you wish. Or you may wish to return to Original Medicare and possibly obtain supplemental health insurance. Whether you enroll in another Medicare+Choice Plan or not, there will be no gap in Medicare coverage. Remember, until returning to Original Medicare coverage, you would still be a Member of *WHA Care+.*

Until you are notified in writing of your WHA Disenrollment, you are still considered a *WHA Care+* Member and must continue to receive Covered Services from Contracted Medical Providers. Neither *WHA Care+* nor Medicare will pay for services received from Non-Contracted Medical Providers, except for Urgently Needed Services, Emergency Services anywhere in the world and Referrals that have received Prior Authorization.

Review of Termination and Reinstatement

No Member shall be Disenrolled because of the Member's health status or requirements for health care services other than as stated within this section. If you believe that you have been Disenrolled by WHA because of your health status or requirements for health care services, you may request a review by the California Commissioner of Corporations, or contact your CMS Regional Office. In the event the Commissioner determines the Disenrollment was contrary to state law, you will be reinstated retroactively to the date of the Disenrollment.

SECTION 9 - APPEAL AND GRIEVANCE PROCEDURES

As a *WHA Care+* Member, you are encouraged to let us know if you have concerns or experience any problems with *WHA Care+.* We have representatives available to help you with your questions and concerns.

The procedures described in this section may be used if you have an appeal or grievance that you want to submit to WHA for review and resolution. These procedures include:

- State of California Complaint Process and Consumer Hotline
- Medicare Standard Appeals Procedure,
- Medicare Expedited/72-Hour Determinations and Appeals Procedure,
- The WHA Grievance Procedure,
- Peer Review Organization (PRO) Immediate Review of Hospital Discharges, and
- PRO Quality of Care Complaint Procedure.

How to File A Grievance

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

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

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

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

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

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

Medicare Appeals Procedure

As a Member of *WHA Care+*, you have the right to appeal any decision about our payment for, or failure to arrange or continue to arrange for, what you believe are Covered Services (including non-Medicare covered Benefits) under *WHA Care+*. Coverage decisions that are commonly appealed include decisions with respect to:

- Payment for Emergency Services, Post-Stabilization Care, or Urgently Needed Services;
- Payment for any other health services furnished by a Non-Contracted Medical Provider or Facility that you believe should have been arranged for, furnished, or reimbursed by *WHA Care+*;
- Services you have not received, but which you feel WHA should pay for or arrange; or
- Discontinuation of services that you believe are Medically Necessary Covered Services.

You should use the WHA Grievance Procedure (discussed below) for complaints that do <u>not</u> involve coverage decisions such as those set forth above relating to provision of or payment for services. If you have a question about what type of complaint process to use, please call WHA Member Services department.

As discussed below, WHA has a standard determination and appeals procedure and an expedited determination and appeals procedure.

<u>Who May File an Appeal</u>

1. You may file an appeal.

2. Someone else may file the appeal for you on your behalf. You may appoint an individual to act as your representative to file the appeal for you by following the steps below:

   a) In a written statement, give us your name, your Medicare number and a statement, which appoints an individual as your representative. (Note: you may also appoint a physician or a Provider.) For example: "I __[*<u>your name</u>*]__ appoint __[*<u>name of representative</u>*]__ to act as my representative in requesting an appeal from *WHA Care+* and/or the Health Care Financing Administration regarding the denial or discontinuation of medical services."

   b) You must sign and date the statement.

   c) Your representative must also sign and date this statement unless he or she is an attorney.

   d) You must include this signed statement with your appeal.

3. A Non-Contracted Physician or other Provider who has furnished you a service may file a standard appeal of a denied claim if he or she completes a waiver of payment statement which says he or she will not bill you regardless of the outcome of the appeal.

Support for Your Appeal

WHA is responsible for gathering all necessary medical information relevant to your request for reconsideration (appeal). However, it may be helpful to include additional information to clarify or support your request. For example, you may want to include in your appeal request information such as medical records or physician opinions in support of your request. To obtain medical records, you may send a written request to your Primary Care Physician. If your medical records from a Specialist are not included in your medical record from your Primary Care Physician, you may need to make a separate request to the Specialist who provided medical services to you.

You have the opportunity to provide additional information in person or in writing. In the case of an expedited decision or appeal, you or your authorized representative may submit evidence, in person, via telephone, or in writing transmitted by a fax machine at the address and telephone number referenced below under the expedited/72-hour review procedure. (Please call WHA Member Services for additional information on the procedures for submitting evidence.)

Assistance With Appeals

Regardless of whether you file a standard appeal or ask for an expedited review, you can have a friend, lawyer or someone else help you. There are lawyers who do not charge unless you win your appeal. Groups such as lawyer referral services can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify. You may want to contact the Area Agency on Aging; the Health Insurance Counseling and Assistance Program (HICAP); or the State Ombudsman (if your request is for Skilled Nursing Facility coverage).

If you have any difficulty finding a phone number for these agencies, please contact the WHA Member Services department at (916) 563-2250 or (888) 563-2250. You can also get help with your appeal from the Medicare Rights Center (toll free) at 1-888-HMO-9050.

Medicare Standard Appeals Procedure

In the case of a Standard Determination and Appeal, WHA must make a determination (decision) on your request for payment or provision of services within the following time frames:

- Request for Service. If you request services, or require Prior Authorization of a Referral for services, WHA must make a decision as expeditiously as your health requires, but no later than fourteen (14) calendar days after receiving your request for service. An extension of up to fourteen (14) calendar days is permitted if you request the extension or if we have a need for additional information and the extension of time benefits you; for example, if we need additional medical records from Non-Contracted Medical Providers that could change a denial decision.

- Requests for Payment. If you request payment for services already received, WHA will make a decision on whether or not to pay the claim no later than 30 calendar days from receiving your request. If for some reason we cannot make the decision in 30 calendar days, we will send you a letter letting you know why; in this case we may take up to an additional 30 calendar days to

make our decision. If the decision is made in your favor, we will make payment within 30 calendar days of the decision date.

WHA must notify you in writing of any adverse decision (partial or complete) within the timeframes listed above. The notice must state the reasons for the denial and also must inform you of your right to reconsideration as well as the appeals process. If you have not received such a notice within fourteen (14) calendar days of your request for services, or within sixty (60) calendar days of a request for payment, you may assume the decision is a denial, and you may file an appeal.

If you decide to proceed with the Medicare Standard Appeals Procedure, the following steps will occur:

1. You must submit a written request for reconsideration to Western Health Advantage, Attention: Appeal and Grievance Coordinator, 1331 Garden Highway, Suite 100, Sacramento, CA 95833-9773. You may also request a reconsideration through the Social Security office (or, if you are a railroad retirement beneficiary, through a Railroad Retirement Benefits Office). You must submit your written request within sixty (60) calendar days of the date of the notice of the initial decision.

   Note: The sixty (60) calendar day limit may be extended for good cause. Include in your written request the reason why you could not file within the 60-calendar day time frame.

2. WHA will conduct a reconsideration and notify you in writing of the decision, using the following timeframes:

   - Request for Service. If the appeal is for a denied service, we must notify you of the reconsideration decision as expeditiously as your health requires, but no later than thirty (30) calendar days from receipt of your request. We may extend this timeframe by up to fourteen (14) calendar days if you request the extension or if we need additional information, and the extension of time benefits you; for example, if we need additional medical records from Non-Contracted Medical Providers that could change a denial decision. We will make a decision as expeditiously as your health requires, but no later than the end of any extension period.

   - Request for Payment. If the appeal is for a denied claim, WHA must notify you of the reconsideration determination no later than 30 calendar days after receiving your request for a reconsideration determination.

3. Persons who make our reconsideration decision are not involved in the initial decision. A physician must make all reconsideration of adverse organization determinations based on "lack of medical necessity" with appropriate expertise in the field of medicine appropriate for the services at issue. During the reconsideration, you or your authorized representative may present or submit relevant facts and/or additional evidence for review either in person or in writing.

4. If we decide to uphold the original adverse decision, either in whole or in part, we will automatically forward the entire file to the Center for Health Dispute Resolution (CHDR) for a new and impartial review. CHDR is CMS's independent contractor for appeal reviews involving Medicare+Choice managed care plans like *WHA Care+*. We must send CHDR the file within 30 calendar days of a request for services or payment. CHDR will either uphold WHA's decision or issue a new decision. If we forward the case to CHDR, we will notify you of our decision as discussed above.

5. For cases submitted for review, CHDR will make a reconsideration decision and notify you in writing of its decision and the reasons for the decision. If CHDR upholds our decision, the notice will inform you of your right to a hearing before an administrative law judge of the Social Security Administration. If CHDR decides in your favor, we must provide or authorize the service or pay the claim within 60 calendar days.

6. If the amount involved is at least $100, you may request a hearing before an administrative law judge (ALJ) by submitting a written request to *WHA Care+*, CHDR or the Social Security Administration within sixty (60) calendar days of the date of CHDR's notice that the reconsideration decision was not in your favor. This sixty (60) calendar day notice may be extended for good cause. All hearing requests will be forwarded to CHDR. CHDR will then forward your request and your reconsideration file to the hearing office. WHA will also be made a party to the appeal at the ALJ level.

7. Either you or WHA may request a review of an ALJ decision by the Departmental Appeals Board (DAB), which may either review the decision or decline review.

8. If the amount involved is $1000 or more, either you or WHA may request that a decision made by the DAB, or the ALJ if the DAB has declined review, be reviewed by a Federal district court.

9. Any initial or reconsidered decision made by WHA, CHDR, the ALJ, or the DAB can be reopened by any party (a) within twelve months, (b) within four (4) years for just cause, or (c) at any time for clerical correction of an error or in cases of fraud.

10. The reconsidered determination is final and binding upon WHA *Care+*. The binding arbitration provision in this evidence of coverage does not apply to disputes subject to CMS's appeals process.

Medicare Expedited/72 -Hour Determination and Appeal Procedure

You have the right to request and receive expedited decisions affecting your medical treatment in "Time-Sensitive" situations. A Time-Sensitive situation is a situation where waiting for a decision to be made within the time frame of the standard decision-making process could seriously jeopardize your life or health, or your ability to regain maximum function.

If WHA decides, based on medical criteria, that your situation is Time-Sensitive or if any physician makes the request for you or calls or writes in support of your request for an expedited review, we will issue a decision as expeditiously as your health requires, but no later than seventy-two (72) hours after receiving the request. We may extend this timeframe by up to fourteen (14) calendar days if you request the extension or if we need additional information, and the extension of time benefits you; for example, if we need additional medical records from Non-Contracted Medical Providers that could change a denial decision. Again, we must make a decision as expeditiously as your health requires, but no later than the end of any extension period.

Types of Decisions Subject to Expedited or 72-Hour Review

1. Expedited Determinations. If you believe you need a service, or continue to need a service, and you believe it is a Time-Sensitive situation, you or any physician (including a physician with no connection to WHA) may request that the decision be expedited. If WHA or any physician decides that yours is a Time-Sensitive situation, we will make a decision on your request for a service on an expedited or 72-hour basis (subject to an extension as discussed above).

2. Expedited Appeals. If you want to request a reconsideration (appeal) of a decision by the Health Plan to deny a service you requested or to discontinue a service you are receiving that you believe is a Medically Necessary Covered Service and you believe it is a Time-Sensitive situation, you may request that the reconsideration (appeal) be expedited. If a physician wishes to file an expedited appeal for you, you must give him or her authorization to act on your behalf. If WHA or any physician decides that yours is a Time-Sensitive situation, we will make a decision on your appeal on an expedited or 72-hour basis. We may extend this timeframe by up to fourteen (14) calendar days if you request the extension, or if we need additional information and the extension of time benefits you; for example, if we need additional medical records from Non-Contracted Medical Providers that could change a denial decision. Again, we must make a decision as expeditiously as your health requires, but no later than the end of any extension period. Examples of service decisions which you may appeal on an expedited basis, when you believe it is a Time-Sensitive situation, include the following:

    - If you received a denial of a service you requested;

    - If you think services are being discontinued too soon. For example:

        – If you think you are being discharged from a Skilled Nursing Facility too soon;

        – If you think your Home Health care is being discontinued too soon;

        – If you think you are being discharged from a Hospital too soon and you have missed the deadline for a Peer Review Organization (PRO) review (please see "Section 9 - Peer Review Organization (PRO) Immediate Review of Hospital Discharges" for more information).

The procedures for requesting and receiving an expedited decision or an expedited appeal are described in the following sections.

How to Request an Expedited/72-Hour Review

To request an expedited or 72-hour review, you or your authorized representative may call, write, fax or visit WHA. Be sure to ask for an expedited/72-hour review when you make your request.

Call: WHA at (916) 563-2250, or (888) 563-2250
Monday through Friday between 8:00 a.m. and 5:00 p.m.
(After business hours, you may leave a voice mail message)

TTY 1-888-877-5378
Monday through Friday between 8:00 a.m. and 5:00 p.m.

Write: ***WHA Care+***
Attention: Expedited Reviews
1331 Garden Highway, Suite 100
Sacramento, CA 95833-9773

Fax: 916-563-3182 (fax machine receives 24 hours per day)
Attention: Expedited Reviews

Walk-in: *WHA Care+*
Member Services
1331 Garden Highway, Suite 100
Sacramento, CA 95833-9773
Monday through Friday between 8:00 a.m. and 5:00 p.m.

How Your Expedited/72-Hour Review Request will be Processed

1. Upon receiving your reconsideration request, WHA will determine if your request meets the definition of Time-Sensitive.

   - If your request does not meet the definition, it will be handled within the standard review process. You will be informed by telephone or in person whether your request will be processed through the expedited seventy-two (72) hour review or the standard review process. You will also be sent a written confirmation within two (2) working days of the phone call. If you disagree with WHA's decision to process your request within the standard timeframe, you may file a grievance with WHA. The written confirmation letter will include instructions on how to file a grievance. If your request is Time-Sensitive, you will be notified of our decision as expeditiously as your health requires but no later than seventy-two (72) hours. You also will be sent a follow-up letter within 2 working days of the phone call.

   - An extension up to fourteen (14) calendar days is permitted for a 72-hour appeal if you ask for the extension or we need more information and the extension of time benefits you; for example, if you need time to provide the us with additional information or if we need to have additional diagnostic testing completed.

2. Your request must be processed within seventy-two (72) hours if any physician calls or writes in support of your request for an expedited/72-hour review, and the physician indicates that applying the standard review timeframe could seriously jeopardize your life or health or your ability to regain maximum function. If a Non-Contracted Medical Provider supports your request, WHA will have 72 hours from the time it receives all the necessary medical information from that Provider.

3. WHA will make a decision on your appeal and notify you of its decision within 72 hours of receipt of your request. If we decide to uphold the original adverse decision, either in whole or in part, WHA will forward the entire appeal file to CHDR for review as expeditiously as your health requires, but no later than 24 hours after our decision. CHDR will send you a letter with its decision within ten (10) working days of receipt of your case from WHA.

If you have questions regarding these rights, please call the WHA Member Services Department at (916) 563-2250 or (888) 563-2250.

WHA Grievance Procedures

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

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

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

Expedited Appeal Review

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

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

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

Peer Review Organization (PRO) Immediate Review of Hospital Discharges

You have the right to receive all the Hospital care that is necessary for the proper diagnosis and treatment of your illness or injury. According to federal law, your discharge date must be determined solely by your medical needs. When you are being discharged from the hospital, you will receive a written notice of explanation called a "Notice of Non-Coverage". This document outlines your rights, and you do not have to disagree with the non-coverage determination in order to receive it. Either WHA or the hospital is required to issue this notice. You have the right to request a review by a Peer Review Organization (PRO) of any written Notice of Non-Coverage that you receive from WHA or from the Hospital on our behalf stating that we will no longer pay for your Hospital care. Such a

request must be made by noon of the first workday after you receive the Notice of Non-Coverage. You cannot be made to pay for your Hospital care until the PRO makes its decision.

PROs are groups of doctors who are paid by the federal government to review Medical Necessity, appropriateness, and quality of Hospital treatment furnished to Medicare patients, including those enrolled in a Medicare+Choice managed care plan like *WHA Care+*. The phone number and address of the PRO for your area is:

California Medical Review, Inc.
Citicorp Center
One Sansome Street, Suite 600
San Francisco, CA 94104-4448
800-841-1602

If you ask for immediate review by the PRO by noon on the workday following a Notice of Non-Coverage, you will be entitled to this process instead of the standard appeals process that is described above in this section. You will also be protected from liability for hospital services until the PRO makes its decision. Instead of PRO review you may appeal the Notice of Non-Coverage within 60 calendar days as discussed above by requesting that WHA reconsider the decision. The advantage of the PRO review is that you will get the results within three working days if you request the review on time. Also, you are not financially liable for hospital charges during the PRO review process. This same protection does not apply in the case of the WHA reconsideration process.

Note: You may file an oral or written request for an expedited or 72-hour appeal to be processed by WHA only if you have missed the deadline for requesting the PRO review. Specifically state that you have missed the immediate PRO review deadline, you want an expedited appeal (or 72-hour) and that you believe your health could be seriously harmed by waiting for a standard appeal.

Peer Review Organization Quality of Care Complaint Process

If you are concerned about the quality of care you have received, you may file a complaint with the Peer Review Organization (PRO) in your local area. (The name, address and telephone number of your local PRO are referenced in the section above.)

State of California Complaint Process and Consumer Hotline

The Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. The DMHC has a toll-free telephone number (888) HMO-2219.
The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers (1-800-735-2929 (TTY) or 1-888-877-5378 (TTY)) to contact the department. The Department's TTY# is (877) 688-9891. The department's Internet website http://www.hmohelp.ca.gov has complaint forms and instructions online. Should you have an appeal or grievance against the health plan, you should contact the Plan and use the Plan's grievance process. If you need the Department's help with a complaint involving an Emergency grievance or with a grievance that has not been satisfactorily resolved by the Plan, you may call the California Department of Managed Health Care's toll-free telephone number.

Independent Medical Review

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

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

If you would like to apply for Independent Medical Review, please call our Member Services Department between 8 a.m. and 5 p.m. Monday through Friday, at (916) 563-2250 / (888) 563-2250 to request the application form. Or, if you prefer, you can come directly to our office or request the form in writing at:

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

Appeal for Investigational/Experimental Treatment

WHA excludes from coverage services, medication or procedures, which are considered investigational and/or experimental treatment and which are not accepted as standard medical practice for the treatment of a condition or illness. If a specific procedure is requested, and after careful review by the appropriate medical personnel, the Plan's determination is that the therapy is experimental or investigational and, therefore, not a covered benefit, the member will be notified of the denial in writing within five (5) business days of the decision.

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

The written request is to be submitted to:

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

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

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

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

If a member with a terminal illness life threatening or severely debilitating condition disagrees with the denial of a service, medication, device or procedure deemed to be experimental, who meet the criteria above, they may request a review by outside medical experts. This request can be made verbally or in writing. The member may also request a face-to-face meeting with WHA's Chief Medical Officer to discuss the case. WHA will gather all medical records and necessary documentation relevant to the patient's condition and will forward all information to an external independent reviewer within five (5) days from the date of the request.

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

The final process for resolving a dispute is arbitration. If you continue to be dissatisfied with the results of the appeals and grievance process and wish to pursue the matter further, you must submit your claim or controversy to binding arbitration within 60 days of completion of the appeals and grievance process.

SECTION 10 - ADVANCE DIRECTIVES: MAKING YOUR HEALTH CARE WISHES KNOWN

We are required by law to inform you of your right to make health care decisions and to execute advance directives. **An advance directive is a formal document, written by you in advance of an incapacitating illness or injury.** As long as you can speak for yourself, Contracted Medical Providers will honor your wishes. But, if you become so sick that you cannot speak for yourself, then this directive will guide your health care Providers in treating you and will save your family, friends and physicians from having to guess what you would have wanted.

There may be several types of advance directives you can choose from, depending on state law. Most states recognize:

- Durable Powers of Attorney for Health Care (DPAHC),
- Living Wills, and
- Natural Death Act Declarations.

This advance directive form allows you to appoint an agent (family, friend or other person) whom you trust to make treatment decisions for you should there come a time you are unable to make them yourself. You can purchase the form from a stationery store or ask for a form from your Contracted Medical Provider or social worker.

It is necessary that you provide copies of your completed directive to:

1. your Primary Care Physician,
2. your agent, and
3. your family.

Be sure to keep a copy with you and take a copy to the Hospital when you are hospitalized for medical care.

You are not required to initiate an advance directive, and you will not be denied care if you do not have an advance directive.

SECTION 11 - COORDINATING OTHER INSURANCE BENEFITS

Who Pays First?

If you do not have end-stage renal disease (ESRD), and have coverage under an employer group plan of an employer of twenty (20) or more employees, either through your own current employment or the employment of a spouse, you must use the benefits under that plan. Similarly, if you do not have end-stage renal disease (ESRD), but have Medicare based on disability and are covered under an employer group plan of an employer of one hundred (100) or more employees (or a multiple employer plan that includes an employer of one hundred or more employees) either through your own current employment or that of a family member, you must use the benefits under that plan. In such cases, you will only receive benefits not covered by your employer group plan through our contract with Medicare (and we will only be paid an amount by Medicare to cover such "wrap around" benefits). A special rule applies if you have or develop ESRD.

If any no-fault or any liability insurance is available to you, then benefits under that plan must be applied to the costs of health care covered by that plan. Where *WHA Care+* has provided health care benefits and a judgment or settlement is made with a no fault or liability insurer, you must reimburse WHA. However, our reimbursement may be reduced by a share of procurement costs (e.g., attorney fees and costs). Workers' compensation for treatment of a work-related illness or injury should also be applied to covered health care costs.

If you have (or develop) ESRD and are covered under an employer group plan, you must use the benefits of that plan for the first thirty (30) months after becoming eligible for Medicare based on ESRD. Medicare is the primary payer after this coordination period. (However, if your employer group plan coverage was secondary to Medicare when you developed ESRD because it was not based on current employment as described above, Medicare continues to be primary payer.)

Since your *WHA Care+* coverage must be coordinated with other insurance you may have, we will ask you for information about other insurance coverage through an "Other Insurance/Coordination of Benefits" survey we will send you each year. If you have other insurance, you can help us obtain payment from the other insurer by providing the information we request promptly.

Coordination of benefits protects you from higher Plan Premiums. The end result is more affordable health care.

SECTION 12 - CONFIDENTIALITY AND RELEASE OF INFORMATION

WHA will make available to you, upon request, its "Confidentiality" policy, and procedure, in which it covers preserving the confidentiality of medical records for our members.

SECTION 13 - GENERAL PROVISIONS

Governing Law

This Combined Evidence of Coverage and Disclosure Information is subject to the laws of the State of California and the United States of America, including: Title XVIII of the Social Security Act and regulations promulgated thereunder by CMS. Any provisions required to be in this Combined Evidence of Coverage and Disclosure Information by any of the above acts and regulations shall bind WHA and you whether or not expressly provided in this document.

Your Financial Liability as a *WHA Care+* Member

As a member of *WHA Care+*, you have the following financial obligations:

- *WHA Care+* Premium - members or the member's employer group are required to pay the monthly Plan Premium.

- All Copayments specified in "Section 15 – *WHA Care+* Schedule of Medical Benefits" of this Combined Evidence of Coverage and Disclosure Information must be paid in addition to any organization premium. Copayments are paid to the physician or provider at the time of service.

- Changes in WHA Premiums - Increases in premiums and/or decreases in the level of coverage are only permitted at the beginning of each contract year and must be approved by CMS. Your employer will receive written notice at least 210 calendar days prior to the date when such change shall become effective.

- Medicare Part B Premium - As a *WHA Care+* member, you must continue to pay your Medicare Part B premium. If you receive a Social Security Administration or Railroad Retirement Board annuity check, this premium is automatically deducted from your check. Otherwise your premium is paid directly to Medicare by you or someone on your behalf (such as your State Medicaid Agency).

WHA has the right to Disenroll you for failure to pay the monthly Plan Premium. However, prior to such action, WHA will a) contact you within 20 calendar days of the date the delinquent charges are due; b) provide you with an explanation of the Disenrollment procedures and any lock-in requirements; c) give you a written notice of Disenrollment, including an explanation of your right to a hearing under WHA's grievance procedures.

Until you are notified of your Disenrollment, you are still a member of *WHA Care+* and you must continue to use Contracted Providers, except for emergencies or urgently needed care.

Member Non-Liability

In the event WHA fails to reimburse a Contracted Medical Provider's charges for Covered Services or in the event that we fail to pay a Non-Contracted Medical Provider for Prior Authorized services, you shall not be liable for any sums owed by WHA.

However, you will be liable if you receive services from Non-Contracted Medical Providers without Prior Authorization, except for Emergency Services or Urgently Needed Services, and neither *WHA Care+* nor Medicare will pay for those services. In addition, if you enter into a private contract with a Non-Contracted Medical Provider, neither *WHA Care+* nor Medicare will pay for those services.

In the event a Contracted Medical Provider's contract with WHA is terminated while you are under a course of care from that Provider, WHA will pay for the continuation of related Covered Services as long as you retain eligibility, until the Covered Services are completed, unless we make a reasonable and medically appropriate arrangement for those services to be provided by another Contracted Medical Provider. A Plan Medical Director or designee shall determine when the Contracted Medical Provider's services are completed and what is a reasonable and medically appropriate arrangement for the provision of the services by another Contracted Medical Provider.

WHA Contracting Arrangements

In order to obtain quality services in an efficient manner, WHA pays its Providers using various payment methods, including capitation, *per diem* and discounted fee-for-service arrangements. Capitation means paying a fixed dollar amount per month for each Member assigned to the Contracted Medical Group. *Per Diem* means paying a fixed dollar amount per day for all services rendered. Discounted fee-for-service means paying the Provider's usual, customary and regular fee discounted by an agreed-to percentage. WHA does not have in place any bonus schedules or financial incentives with its contracting providers, which artificially restrict or limit the amount of care,

which is provided under *WHA Care+*.

You are entitled to ask if we have special financial arrangements with our physicians that can affect the use of Referrals and other services that you might need. To get this information, call our Member Services department at (916) 563-2250 or (888) 563-2250 and request information about our physician payment arrangements.

Physician-Patient Relationship

WHA Care+ does not prohibit or otherwise restrict a provider, acting within the lawful scope of practice, from advising or advocating on your behalf about:

- your health status, medical care, or treatment options;
- the risk, benefits, and consequences of treatment or non-treatment; or
- the opportunity for you to refuse treatment and to express preferences about future treatment decisions.

Facility Locations

Medical services are provided to *WHA Care+* Members through physicians affiliated with WHA Contracted Medical Groups, Contracted Medical Providers, Contracted Hospitals, and Contracted Pharmacies. For a complete list of Providers, please refer to the *WHA Care+* Provider Directory. If you have any questions regarding the Providers listed in the directory, please contact the WHA Member Services department.

For twenty-four (24) hour Emergency and/or Urgent visit telephone numbers, refer to either the *WHA Care+* Provider Directory or your membership card.

Notices

Any notice required to be given under this Combined Evidence of Coverage and Disclosure Information shall be in writing and either delivered personally or by United States mail at the addresses set forth below or at such other address as the parties may designate:

If to WHA: ***WHA Care+***
Attn: Member Services
1331 Garden Highway, Suite 100
Sacramento, CA 95833-9773

If to you, to your last known address according to WHA's records.

Additional Information

As a *WHA Care+* Member, you have the right to request information on the following:

- General coverage and comparative plan information,
- Utilization control procedures,

- Statistical data on Grievances and Appeals,
- The financial condition of WHA, and
- A summary of Provider compensation arrangements.

Please contact WHA Member Services department at (916) 563-2250 or (888) 563-2250.
You may write to the WHA Corporate Offices at:

WHA Care+
Attention: Member Services
1331 Garden Highway, Suite 100
Sacramento, CA 95833-9773

SECTION 14 - *WHA CARE+* SERVICE AREA

You are eligible for enrollment and continued coverage as long as you reside within the *WHA Care+* Service Area, as indicated by the zip codes below:

Placer County: 95765 95677 95650 95746 95661 95678 95747

Sacramento County: all zip codes

Solano County: 94512 94533 94535 94571 94585 95620 95625 95687 95688 95694 95696

Yolo County: all zip codes

SECTION 15 *WHA CARE+* SCHEDULE OF MEDICAL BENEFITS

The first column describes medical benefits as defined by CMS. The second column describes what Medicare will cover towards the cost and scope of the benefit. The third column represents your share of the cost (copayment) as well as any additional benefit or clarification, which applies to your coverage through *WHA Care+.* Please also see "Section 16 – General Exclusions: Services Not Covered" for additional information regarding Exclusions and limitations.

Inpatient Care	Original Medicare	*WHA Care+*
Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services	You pay for each benefits period (3): Days 1-60: an initial deductible of $812 Days 61-90: $203 each day Days 91-150: $406 each lifetime reserve days (4) Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. (4)	There is a $250 copayment for Inpatient Hospital services in a network hospital. You are covered for unlimited days each benefit period.(3)
Inpatient Mental Health Care	You pay the same deductible and Copayments as inpatient hospital care (above) except there is a 190-day lifetime limit in a psychiatric hospital.	There is a $250 copayment for services in a network hospital. There is a 190-day lifetime limit in a psychiatric hospital.

(3) 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 deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

Inpatient Care	Original Medicare	*WHA Care+*
Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	You pay for each benefit period [3], following at least a 3-day covered hospital stay: Days 1-20: $0 for each day Days 21-100: $99 for each day There is a limit of 100 days each benefit period. [3]	There is no copayment for services in a Skilled Nursing Facility. You are covered for 100 days each benefit period.[3] No prior hospital stay is required.
Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must receive care from any Medicare-certified hospice.	There is no copayment for Hospice care. You must receive care from a Medicare-certified hospice.
Doctor Office Visits	You pay 20% of Medicare-approved amounts. [1] [2]	You pay $10 for each primary care doctor office visit for Medicare- covered services. You pay $10 for each specialist visit for Medicare-covered services. See Routine Physical Exams for more information.

(1) Each year, you pay a total of one $100 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.

(3) 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 deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

Outpatient Care	Original Medicare	*WHA Care+*
Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	There is no copayment for all covered home health visits.	There is no copayment for Medicare- covered home health visits.
Chiropractic Services	You pay 20% of Medicare-approved amounts.(1) (2) You are covered for manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers. You pay 100% for routine care.	You pay $10 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).
Podiatry Services	You pay 20% of Medicare-approved amounts.(1) (2) You are covered for medically necessary foot care, including care for medical conditions affecting the lower limbs. You pay 100% for routine care.	You pay $10 for each Medicare-covered visit (medically necessary foot care).
Outpatient Mental Health Care	You pay 50% of Medicare-approved amounts with exception of certain situations and services for which you pay 20% of approved charges. (1) (2)	For Medicare-covered Mental Health services, you pay: ▪ $10 for individual/group therapy visit(s) 1 and beyond. For Medicare-covered Mental Health services with a psychiatrist, you pay: ▪ $10 for individual/group therapy visit(s) 1 and beyond.

(1) Each year, you pay a total of one $100 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.

Summary of Benefits Outpatient Care	Original Medicare	*WHA Care+*
Outpatient Substance Abuse Care	You pay 20% of Medicare-approved amounts.(1) (2)	For Medicare-covered services, you pay: ▪ $10 for individual/group visit(s) 1 and beyond.
Outpatient Surgery	You pay 20% of Medicare-approved amounts for the doctor.(1) (2) You pay 20% of outpatient facility charges.(1) (2)	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 (medically necessary ambulance services)	You pay 20% of Medicare-approved amounts or applicable fee schedule charge.(1)	There is no copayment for Medicare-covered ambulance services.
Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	You pay 20% of the facility charge or applicable Copayment for each emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within 3 days of the emergency room visit.(1) (2) You pay 20% of doctor charges.(1) (2) NOT covered outside the U.S. except under limited circumstances.	You pay $50 for each Medicare-covered emergency room visit; If admitted you pay $250 per admission. Worldwide coverage.

(1) Each year, you pay a total of one $100 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.

Summary of Benefits Outpatient Care	Original Medicare	*WHA Care+*
Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	You pay 20% of Medicare-approved amounts or applicable Copayment. (1) (2) NOT covered outside the U.S. except under limited circumstances.	You pay $50 for Medicare-covered urgently needed care visit; if admitted you pay $250 per admission. Worldwide coverage.
Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	You pay 20% of Medicare-approved amounts. (1) (2)	You pay $10 for each Medicare-covered Occupational Therapy visit. You pay $10 for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit.
Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	You pay 20% of Medicare-approved amounts. (1) (2)	There is no copayment for Medicare-covered items.
Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	You pay 20% of Medicare-approved amounts. (1) (2)	There is no copayment for Medicare-covered items.

(1) Each year, you pay a total of one $100 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.

Diabetes Self-Monitoring Training and Supplies (includes coverage for glucose monitors, test strips, lancets, and self management training)	You pay 20% of Medicare-approved amounts. (1) (2)	There is no copayment for Diabetes self-monitoring training. You pay $10 for each Medicare- covered Diabetes Supply item.
Diagnostic Tests, X-Rays, and Lab Services	You pay 20% of Medicare-approved amounts, except for approved lab services. (1) (2) There is no copayment for Medicare-approved lab services.	There is no copayment for the following Medicare-covered service(s): ▪ Clinical lab services ▪ Diagnosis lab services ▪ X-Ray visits
Radiation Therapy	You pay 20% of Medicare approved amounts. (1) (2)	There is no copayment for each Medicare-covered radiation therapy service.
Bone Mass Measurement (for people with Medicare who are at risk)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no copayment for each Medicare-covered Bone Mass Measurement.
Colorectal Screening Exams (for people with Medicare age 50 and older)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no copayment for: ▪ Medicare-covered Colorectal Screening Exams. ▪ Additional screening exams up to 1 exam(s) every two years.

(1) Each year, you pay a total of one $100 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.

Preventive Services (continued)		
Immunizations (Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, Pneumonia vaccines)	There is no copayment for the Pneumonia vaccine and flu vaccine. You pay 20% of Medicare-approved amounts. (1)	There is no copayment for the Pneumonia vaccine and flu vaccine. There is no copayment for the Hepatitis B vaccine.
Mammograms (Annual Screening) (for women with Medicare age 40 and older)	You pay 20% of Medicare-approved amounts. (2)	There is no copayment for: ▪ Medicare-covered screening mammograms ▪ Additional screening mammograms You are covered for unlimited number of Screening Mammograms.
Pap Smears and Pelvic Exams (for women with Medicare)	There is no copayment for a Pap Smear once every 2 years, annually for beneficiaries at high risk. (2) You pay 20% of Medicare-approved amounts for Pelvic Exams. (2)	You pay: $0 for each Medicare-covered Pap Smear. $0 for each additional Pap Smear up to 1 Pap Smear(s) every year $10 For each Medicare-covered Pelvic Exam.
Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	There is no copayment for approved lab services and a copayment of 20% of Medicare-approved amounts for other related services. (2)	There is no copayment for: ▪ Medicare-covered Prostate Cancer Screening exams ▪ Additional screening exams up to 1 exam(s) every year.

(1) Each year, you pay a total of one $100 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.

Additional Benefits (What Original Medicare does Not Cover)		
Outpatient Prescription Drugs Drugs and medicines you buy with a doctor's prescription.	Medicare does not cover outpatient prescription drugs except for immunosuppressive drugs and under certain other conditions. You pay 100% for most prescription drugs.	**30 day supply:** ▪ $10 copayment for Generic ▪ $20 copayment for Brand Name ▪ $35 copayment for Non-formulary **Mail-order (90 day supply)** ▪ $20 copayment for Generic ▪ $40 copayment for Brand Name ▪ $70 copayment for Non-formulary Generic required if available. Brand name medication dispensed if requested by the physician or Member; the Member will pay the Brand copayment plus the difference in cost between Generic and Brand Name. If there is no generic equivalent, Brand name copayment applies. You must use designated retail pharmacies and Mail Order to get your prescription drugs.
Drugs for the treatment of sexual dysfunction.	Not Covered	Covered at 50% copayment, Viagra is limited to 8 pills per 30-day supply.

Additional Benefits (What Original Medicare does Not Cover)		
Dental Services	In general, you pay 100% for dental services.	In general, you pay 100% for non-Medicare covered dental services.
Hearing Services	You pay 100% for routine hearing exams and hearing aids. You pay 20% of Medicare-approved amounts for diagnostic hearing exams. (1)(2)	You pay: ▪ $10 for each Medicare-covered hearing exam (diagnostic hearing exams). ▪ $10 for each routine hearing test up to 1 test(s) every year. ▪ One device per ear every 36 months with a $10 copayment. ($2000 benefit maximum)
Vision Services	You are covered for one pair of eyeglasses or contact lenses after each cataract surgery. (1) (2) For people with Medicare who are at risk, you are covered for annual glaucoma screenings. (1) (2) You pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye. (1) (2) You pay 100% for routine eye exams and glasses.	You pay: ▪ $0 for Medicare-covered eye wear (one pair of eyeglasses or contact lenses after cataract surgery). ▪ $10 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye). ▪ $10 for each Routine eye exam, limited to 1 exam(s) every year ▪ $20 for glasses, limited to 1 pair(s) of glasses every two years

(1) Each year, you pay a total of one $100 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.

Vision Services (continued)		▪ $20 for contacts, limited to 1 pair(s) of contacts every two years You are covered up to $75 for eye wear every two years. No referral necessary for eye exams for any network providers. No referral necessary for eye wear for any network providers.
Routine Physical Exams	You pay 100% for routine physical exams.	You pay $10 for each exam. You are covered for an unlimited number of exams.
Health/ Wellness Education	You pay 100%	There is no copayment for the following: ▪ Health Ed classes ▪ Newsletter

SECTION 16 - GENERAL EXCLUSIONS: SERVICES NOT COVERED

Any services not provided or arranged by a Contracted Medical Provider or Prior Authorized (except for Emergency Services or Urgently Needed Services) are not covered by *WHA Care+* or by Medicare.

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

In addition to any Exclusions or limitations described in "Section 15 – *WHA Care+* Schedule of Medical Benefits", the following items and services are limited or Excluded under *WHA Care+*:

- Any services or supplies obtained prior to the Member's effective date of coverage.
- Non-Urgently Needed Services or non-Emergency Services and supplies rendered by non-Contracted Medical Providers without written referral by the Member's Primary Care Physician. Care by non-Contracted Medical Providers will only be provided as a Covered Service if the care is not available through Contracted Medical Providers and determined to be Medically Necessary.
- Homemaker services, except for limited coverage in accordance with Medicare guidelines.
- Hospice services in a Medicare-participating Hospice are not paid for by WHA, but are reimbursed directly by Medicare when you enroll in a Medicare-certified Hospice. We will refer you to a Medicare-participating Hospice if you wish to elect such coverage. You may remain enrolled in *WHA Care+* even though you have elected Hospice coverage. You may continue to have your care unrelated to the terminal condition arranged through WHA and you may also use a Contracted Medical Provider as your Hospice attending physician.
- Long-term care beyond those which Medicare would cover, including, but not limited to, Skilled Nursing Care and respite care, except as determined by WHA to be less costly alternatives to the basic minimum benefits.
- Meals delivered to your home.
- Naturopaths' services.
- Nursing care on a full-time basis in your home.
- Orthopedic shoes, unless they are part of a leg brace and are included in the orthopedist's charge, except *WHA Care+* will cover therapeutic shoes for those suffering from diabetic foot disease as outlined in "Section 15 – *WHA Care+* Schedule of Medical Benefits" under "Other Services and Supplies".
- Experimental medical or surgical procedures, services or supplies. Please refer to the "Section 1 – Health Care Terms" for "Experimental" criteria.

- Cosmetic services and supplies. The exclusion includes services and supplies performed in connection with the reformation of sagging skin, the enlargement, reduction or change in the appearance of a portion of the body, hair transplant or analysis, chemical face peels or abrasions of the skin.

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

  a) Psychosocial speech delay and language development;
  b) Mental Retardation, Downs Syndrome, Autism or Dyslexia;
  c) Other syndromes attributing to perceptual and conceptual dysfunctions, attention deficit disorder or behavioral problems; and
  d) Developmental articulation and other language disorders.

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

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

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

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

- Dental care, except for:

  a) non-dental surgical and hospitalization procedures incidental to facial fractures, tumors or congenital defects, such as cleft lip or cleft palate, or
  b) surgery on the maxilla or mandible to correct temporomandibular joint disease (TMJ), or
  c) other medical conditions, when Medically Necessary and Prior Authorized.

- Other excluded dental services are:

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

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

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

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

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

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

- Acupuncture, acupressure, biofeedback, sex therapy, dance therapy and recreational therapy.

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

- Infertility testing and treatment, including services and supplies in connection with the reversal of voluntary sterilization.

- Transsexual surgery.

- Custodial care, or services and supplies furnished by an institution, which is primarily a place for rest and provides primarily non-nursing supervision of the patient. Other excluded services include homemaker services. Custodial Care also includes care that assists Members in the activities of daily living, like walking, getting in and out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets; and supervision of medication that is usually self-administered.

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

- Smoking cessation products and programs.

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

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

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

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

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

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

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

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

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

- Testing for the sole purpose of determining paternity.

- Services and supplies rendered by non-Contracted Medical Providers are covered for Urgently Needed Service and Emergency Services only, or when a Contracted Medical Provider is not available through the participating panel and Prior Authorization has been obtained.

- Private duty nurses. However, special duty nursing may be available with medical necessity.

- Routine chiropractic and foot care is generally not covered under *WHA Care+* and is limited according to Medicare guidelines.

- Private room in a Hospital, unless Medically Necessary.

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

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

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

In addition to the above Exclusions and limitations, the covered prescription medications described in this Combined Evidence of Coverage and Disclosure Information are subject to the Exclusions and limitations set forth below:

- Generic medications are required. Brand Name medication is dispensed if requested by physician or Member; the Member will pay the Brand Name copayment plus the difference in cost between Generic and Brand Name.

- Covered prescription medications are limited to a 30-day supply, with the payment of a single Copayment. Prescriptions for controlled substances and other drugs not intended for continuous use may be limited to a smaller quantity per Copayment.

- Covered prescription medications that are to be taken beyond 60 days are considered maintenance medications, and may be obtained through WHA's Mail Order Program. The initial prescription for maintenance medications may be dispensed through a Contracted Pharmacy (limited to a 30-day supply). Subsequent refills for a 90-day supply may be obtained with the payment of two 30-day Copayments through the mail order program.

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

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

- Medications that are not Medically Necessary are excluded.

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

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

- Prescriptions written by dentists are excluded.

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

- Some prescription medications may require Prior Authorization. For clarification, please contact the WHA Member Services department.

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