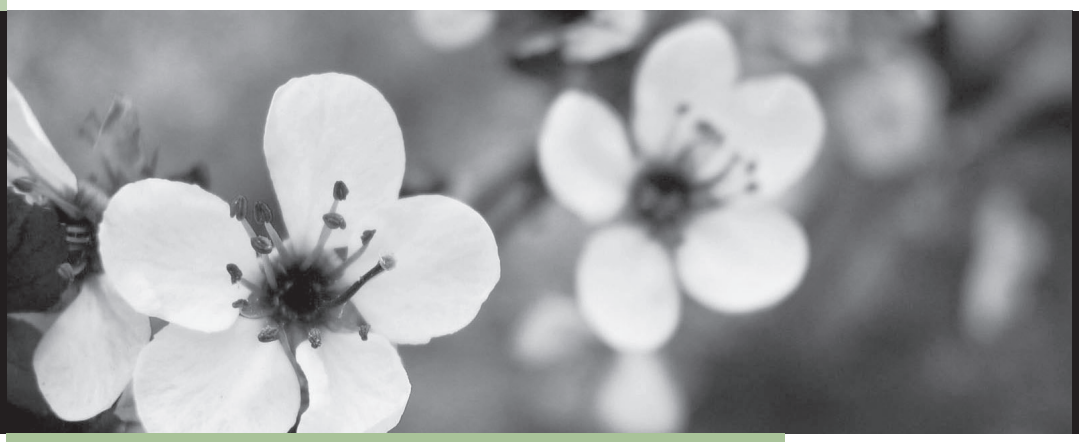
University of California 2008



Combined Evidence of Coverage

And Disclosure Form

Western Health Advantage

2008

UC 106A

Group # 00-1021

(For Your Reference)

MEMBER NAME _____

ADDRESS _____

TELEPHONE NUMBER _____

ELIGIBILITY DATE _____

NAME OF PCP _____

PCP'S ADDRESS _____

PHARMACY LOCATION _____

PHARMACY TELEPHONE NUMBER _____

24-HOUR EMERGENCY CARE TELEPHONE NUMBER _____

Changes for 2008

Please make note of the following changes and/or clarifications to your plan effective January 1, 2008.

Changes

General Changes throughout the booklet

- Plan effective date changed from January 1, 2007 to January 1, 2008 ..... All pages
- WHA address change to 2349 Gateway Oaks Dr., Suite 100..... All pages

Other Changes **Page**

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

Table of Contents

Privacy Notice

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

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

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

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

Protecting Your Privacy

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

Protected Health Information (PHI)

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

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

How We Use Your PHI

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

Treatment

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

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

Payment

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

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

Health Care Operations

WHA may use and disclose your PHI in order to administer our health plan. For example, WHA may use and disclose your health information to support various business

activities without your written authorization. Health care operations are activities related to the normal business functions of WHA. For example, we may share information with others for any of the following purposes:

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

Other Permitted Uses and Disclosures

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

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

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

Sharing Your PHI with Others

As part of normal business, WHA shares your information with contracted Plan Providers (i.e. medical groups, hospitals, pharmacy benefit

management companies, social service providers, etc.). In all cases where your PHI is shared with Plan Providers, we have a written contract that contains language designed to protect the privacy of your health information. Our Plan Providers are required to keep your health information confidential, and protect the privacy of your information in accordance with State and Federal law.

Your Rights With Respect to Your PHI

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

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

Right to Request Restrictions

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

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

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

Right to Inspect and Copy

You and your personal representative have the right to review or obtain copies of your PHI that may be used to make decisions about you. This includes medical records and billing records. It does not include the following: psychotherapy notes, information to be used in a lawsuit or administrative proceedings, and certain information subject to a law concerning laboratory improvements. Your request must be in writing and provide us with specific information needed to fulfill your request. If you call Member Services at (916) 563-2252 or (888) 563-2252 or TTY for the hearing impaired at (888) 877-5378, we will send you a form to use to do this. Or if you prefer, you may send your written request to our Member Services Department at the address listed in the “Complaints” section of this Notice. If you request copies, we can charge a reasonable fee for the cost of producing the copies and postage. You must pay this fee before we give you the copies. You may also request that we provide you with summary information about your PHI instead of all the information. If so, you must pay us the cost of preparing this summary information before we give it to you.

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

physical safety of you or of another person. Our letter will also tell you about any other rights you have to file a complaint. These are the same rights described in this Notice.

Right to Request an Amendment

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

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

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

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

Right to Receive Confidential Communications

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

Right to Receive an Accounting of Disclosures

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

All requests for an accounting must be in writing and include specific information needed to fulfill your request. This accounting requirement applies for six years from the date of the disclosure, beginning with disclosures occurring after April 14, 2003, unless you request a lesser period of time. If you request this accounting more than once in a 12-month period, we may charge you a reasonable fee to produce the accounting of disclosures. Before doing so, we will notify you of the fee, and give you an opportunity to withdraw or limit your request in order to reduce the fee.

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

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

Right to Copies of this Notice

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

How to Complain about Our Privacy Practices

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

Complaints to WHA

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

Western Health Advantage
Attn: Privacy Complaints
2349 Gateway Oaks, Suite 100
Sacramento, CA 95833
(916) 563-3180 or (888) 563-2252

Complaints to the Federal Government

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

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

How to Obtain Additional Information about This Notice

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

Changes to this Notice

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

Questions

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

WHA Privacy Officer
Western Health Advantage,
2349 Gateway Oaks, Suite 100,
Sacramento CA 95833,
(916) 563-2252 or (888) 563-2252.

Effective Date of this Notice

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

UC106A
COPAYMENT SUMMARY

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY.THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

DEDUCTIBLE	**YOU PAY**
Deductible amount	None

ANNUAL OUT-OF-POCKET MAXIMUM

All copayments listed on this Copayment Summary not marked with a * apply to the out-of-pocket maximum.
The maximum out-of-Pocket expense for Members per calendar year is limited to:

Individual	$1,000
Family	$3,000
Lifetime maximum	None

PROFESSIONAL SERVICE	**YOU PAY**
Office visits for adult and pediatric care	$15 per visit
Well-baby care — birth up to two years	Covered in full
Maternity care, after the initial diagnosis, Pre & post natal	Covered in full
Office-administered preventive inoculations	Covered in full
Office-administered injectable drugs (except for Sexual Dysfunction)	$15 copay
Preventive physical examinations	Covered in full
Office visits for consultation or care by a non-primary provider when referred by your primary care physician	$15 per visit
Allergy testing	$15 per visit
Eye and hearing examinations (all ages)	$15 per visit
Family planning services	$15 per visit

OUTPATIENT SERVICES	**YOU PAY**
Surgical Procedures	$15 per visit
Outpatient Transgender Surgery and related outpatient surgery services, outpatient office visits, and related services **	$15 per visit
Laboratory, X-ray, electrocardiograms and all other test	Covered in full
Therapeutic injections, including allergy shots	$5 per visit
Infertility testing and treatment services, including drugs provided	50% copay*
All generally accepted cancer screening tests	Covered in full

HOSPITALIZATION SERVICES	**YOU PAY**
Facility fees — semi-private room and board and hospital services for acute care or intensive care, including:	$250 per admission

- Newborn delivery (private room when determined medically necessary by a participating provider)
- Use of operating and recovery room, anesthesia, inpatient drugs, X-ray, laboratory, radiation therapy and nursery care for newborn babies
- Medical, surgical, and cardiac intensive care
- Blood transfusion services
- Inpatient Transgender Surgery and services related to the surgery **(Limited Coverage)

Professional inpatient services, including:

- Physicians' services, including surgeons and consultants
- Private-duty nurse when prescribed by a participating physician

URGENT AND EMERGENCY SERVICES	**YOU PAY**
Outpatient care to treat an injury or the sudden onset of an acute illness within or out of the WHA Service Area:	
Physician's office	$15 per visit
Urgent care center (plan provider facility only)	$15 per visit
Hospital emergency room (waived if admitted)	$50 per visit
Ambulance service as medically necessary or in a life-threatening emergency (including 911)	Covered in full

PRESCRIPTION COVERAGE*

Retail (up to 30-day supply)

Preferred Generic Medications	$10 copay
Preferred Brand Name Medications	$20 copay
Non-Preferred Medications	$35 copay
Oral/Self-Injectables — Sexual Dysfunction 8 doses per 30-day supply	50% copay
Self-Injectables — Insulin	$20 copay

Retail UC Davis Medical Center Pharmacy (up to 90-day supply)

Preferred Generic Medications	$20 copay
Preferred Brand Name Medications	$40 copay
Non-Preferred Medications	$70 copay

Self-Injectables (except for insulin & sexual dysfunction)

Preferred Generic Medications	$10 copay
Preferred Brand Name Medications	$20 copay
Non-Preferred Medications	$35 copay

Mail Order (90 day supply)

Preferred Generic Medications	$20 copay
Preferred Brand Name Medications	$40 copay
Non-Preferred Medication	$70 copay

DURABLE MEDICAL EQUIPMENT (DME)

Durable Medical Equipment and prosthetic/orthotic devices when determined by a participating physician to be medically necessary and when authorized in advance by WHA ..... Covered in full

BEHAVIORAL HEALTH & CHEMICAL DEPENDENCY

BEHAVIORAL HEALTH & CHEMICAL DEPENDENCY SERVICES ARE PROVIDED BY UNITED BEHAVIORAL HEALTH (UBH). PLEASE CONTACT UBH AT (800) 424-1778 TO ACCESS YOUR BEHAVIORAL HEALTH & CHEMICAL DEPENDENCY BENEFITS.

HOME HEALTH SERVICES

Home health care when prescribed by a participating physician and determined to be medically necessary, up to 100 visits in a calendar year ..... Covered in full

OTHER HEALTH SERVICES

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

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

Outpatient Rehabilitation	$15 per visit
Inpatient Rehabilitation	$250 per admission

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

*Copayments do not contribute to the Out-of-Pocket Maximum.

**Transgender surgery and services related to the surgery require prior authorization by WHA and are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member, and applicable copayment, if any.

Introduction

Welcome to Western Health Advantage

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

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

This EOC/DF is a summary of the group health plan. The Contract between WHA and your Employer, that has sponsored your participation in this health plan, must be consulted to determine the exact terms and conditions of coverage. You may request to see the Contract from your Employer. An applicant has the right to view the EOC/DF prior to enrollment. You may request a copy of the EOC/DF directly from the plan by calling (916) 563-2252 or (888) 563-2252, or view the document on our Web page westernhealth.com.

By enrolling or accepting services under this health plan Members are obligated to understand and abide by all terms, conditions and provisions of the Contract and this EOC/DF.

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

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

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

If you have any questions after reading this EOC/DF or at any other time, please contact Member Services at (916) 563-2252 or (888) 563-2252. Thank you for choosing Western Health Advantage.

Choice of Physicians and Other Providers

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

As a Member of WHA, you have access to a large network of Participating Providers from which to choose your Primary Care Physician (PCP). These providers are conveniently located throughout the WHA Service Area.

All non-Emergency care must be accessed through your PCP, with the exception of obstetrical and gynecological services, which may be obtained through direct access without a referral. Your PCP is responsible for coordinating health care you receive from specialists and other medical providers. Referral requirements will be described later in this EOC/DF.

Some hospitals and other providers do not provide one or more of the following services that may be covered under your EOC/DF and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at

the time of labor and delivery; infertility treatments; abortion; or transgender services. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call WHA's Member Services Department at (916) 563-2252 or (888) 563-2252 to ensure that you can obtain the health care services that you need.

WHA Participating Providers include a wide selection of PCPs, specialists, hospitals, laboratories, pharmacies, ambulance services, skilled nursing facilities, home health agencies and other ancillary care services. You will be provided with a copy of WHA's Provider Directory; which at the time it was printed and sent was current. However, this list is updated and reprinted four times a year, so changes may have occurred that could affect your physician choices. If you need another copy of the directory, contact Member Services at (916) 563-2252 or (888) 563-2252. To view our online Provider Directory WHA's website address is westernhealth.com

Liability of Member for Payment

Copayments

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

Your Liability for Payment

Our contracts with our Contracted Medical Groups provide that you are not liable for any amounts we owe. However, you will be liable for the cost of non-covered Services or for Services you obtain from non-participating providers.

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

Participating Providers

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

Non-Participating Providers

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

How to Use WHA

Selecting Your Primary Care Physician

When you enroll in WHA, you must select a Primary Care Physician (PCP) for yourself and each of your covered Family Members. Each new Member must select a PCP close enough to his or her home or place of work to allow reasonable access to care. You may designate a different PCP for each Member if you wish. Your PCP is responsible for coordinating your health care by either direct treatment or referral to a participating specialist. All non-Urgent Care or non-Emergency Care should be received from your PCP or other Participating Provider as referred by your PCP.

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

Changing Your Primary Care Physician

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

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

Transferring to another Primary Care Provider or Medical Group

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

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

Exceptions

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

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

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

Referrals to Specialists

Advantage Referral

In order to expand the choice of specialists for you, WHA implemented a unique program called “Advantage Referral”. The Advantage Referral program allows Members to access most of the specialty physicians within WHA’s network (listed in the Provider Directory), instead of limiting each Member’s access to those specialists who have a direct relationship with the Member’s PCP. While your PCP will treat most of your health care needs, if your PCP determines that you require specialty care, your PCP will refer you to an appropriate provider. You may request to be referred to any of the WHA network specialists who participate in the Advantage Referral program. Your WHA Provider Directory designates the providers who do not participate in the Advantage Referral program.

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

OB/GYN services for women and annual eye exams are included in the Advantage Referral program and do not require a PCP referral or Prior Authorization, as long as the provider is listed in the WHA Provider Directory and participates in the Advantage Referral program.

If you have a certain life-threatening, degenerative or disabling condition or disease requiring specialized medical care over a prolonged period of time, including HIV or AIDS, you may be allowed a standing referral. A standing referral is a referral for more than one visit, to a specialist or “specialty care center” that has demonstrated expertise in treating a medical condition or disease involving a complicated treatment regimen that requires ongoing monitoring. Those specialists designated as having expertise in treating HIV or AIDS are designated with an asterisk in our Provider Directory under their licensed specialty.

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

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

Urgent Care: When an Urgent Care situation arises while you are in WHA’s Service Area call your PCP any time of the day, including evenings and weekends. Your doctor or the Physician on call will direct your care. (See Definitions for Urgent Care.)

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

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

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

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

Prior Authorization

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

Necessary as determined by WHA or the Medical Group.

Prior Authorization is required for:

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

Requests for Prior Authorization will be authorized or denied within a timeframe appropriate to the nature of the Member's condition. In non-Urgent situations, a decision will be made within five (5) business days of WHA's or the Medical Group's receipt of the information requested that is reasonably necessary to make the decision. If the Member's condition poses an imminent and serious threat to the Member's health, or the normal timeframe for the decision-making process would be detrimental to the Member's health or would jeopardize the Member's ability to regain maximum function, the decision will be made within 72 hours of receipt of the requested information. Any Prior Authorization is conditioned upon the Member being enrolled at the time the Covered Services are received. If the Member is not properly enrolled or if coverage has ended at the time the services are received, the Member will be responsible for the cost of the services.

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

Second Medical Opinions

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

All requests for second medical opinions should be directed to the Member's PCP. Members may also contact WHA's Member Services Department at (916) 563-2252 or (888) 563-2252 for assistance or for additional information regarding second opinion procedures. Decisions regarding second medical opinions will be authorized or denied within the following timelines:

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

Urgent Care and Emergency Care

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

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

If an **Emergency** situation arises whether you are in WHA's Service Area or outside of the

Service Area, call “911” immediately or go directly to the nearest hospital Emergency Room. If an **Urgent Care** situation arises while you are in WHA’s Service Area, call your PCP. You can call your doctor at any time of the day, including evenings and weekends. Explain your condition to your doctor or the Physician on-call and they will direct your care. In the event you are not able to reach your physician, you may go to an Urgent Care Center affiliated with your medical group.

If you are hospitalized at a non-participating facility because of an Emergency, WHA must be notified within 24 hours or as soon as possible. This telephone call is extremely important. If you are unable to make the call, have someone else make it for you, such as a Family Member, friend or hospital staff member. WHA will work with the hospital and Physicians coordinating your care and, if possible, arrange for your transfer to a participating hospital as well as make appropriate payment provisions.

Follow-Up Care

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

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

Provider Network Adequacy

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

Direct Access to Qualified Specialists for Women’s Health Services

WHA provides women access to participating providers — gynecologists, obstetricians, certified nurse midwives, and other qualified health care practitioners for routine and preventive women’s health services.

Access to Specialists

Members with complex or serious medical conditions who require frequent specialty care can arrange for direct access to a network specialist. To ensure continuity of care, WHA has processes in place, which provide for ongoing authorizations and or referrals to a particular specialist for a chronic or serious medical condition for up to a year at a time, if applicable.

Transition of Care and Continuity of Care

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

- An acute condition (care continued for the duration of the acute condition).
- A serious chronic condition. A serious chronic condition is a medical condition due to disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure, worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Covered Services will be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by WHA in consultation with the Member and the terminated or non-Participating Provider

consistent with good professional practice. Completion of Covered Services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly enrolled member.

- A pregnancy (care continued for the duration of the pregnancy and the immediate postpartum period).
- A terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less) (care continued for the duration of the terminal illness.
- Care of a newborn child whose age is between birth and age 36 months (care continued for a period not to exceed 12 months).
- Performance of surgery or other procedure that has been authorized by WHA or the Medical Group as part of a documented course of treatment that is to occur within 180 days.

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

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

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

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

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

circumstances will be evaluated by the Medical Director on a case-by-case basis. To request a copy of our continuity of care policy, please call our Member Services Department at (888) 563-2252, or (916) 563-2252.

Your contracted Medical Group must preauthorize or coordinate services for continued care. If you have any questions, or want to appeal a denial, call our Member Services Department at (916) 563-2252 or (888) 563-2252, Monday through Friday, 8:00 AM to 5:00 PM.

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

Access to Emergency Services

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

Member Rights and Responsibilities

General Information

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

What are my rights?

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

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

- To reasonable continuity of care along with advance knowledge of the time and location of an appointment, as well as, the name of the practitioner scheduled to provide your care.
- To be advised if the physician proposes to engage in, or perform, human experimentation within the course of care or treatment and the ability to refuse to participate in such research projects if desired.
- To be informed of continuing health care requirements following discharge from a hospital or practitioner's office.
- To examine and receive an explanation of bills for services regardless of the source of payment.
- To have these member rights apply to a person with legal responsibility for making medical care decisions on your behalf. This person may be your physician.
- To have access to your personal medical records.
- To formulate advance directives for health care.

What are my responsibilities?

It is the expectation of WHA and its providers that enrollees adhere to the following member responsibilities to facilitate the provision of high level quality of care and service to members. Your member responsibilities include, but are not limited to, the following:

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

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

- Upon the request of a member, disclose to consumers factors such as; methods of compensation, ownership of or interest in healthcare facilities, that can influence advice or treatment decisions;
- Ensure that provider contracts do not contain any so-called "gag clauses" or other contractual mechanisms that restrict the healthcare provider's ability to communicate with or advise patients about medically necessary treatment options.

Principal Benefits and Covered Services

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

NOTE: A full description of exclusions and limitations can be found in the Principal Exclusions and Limitations section of this EOC/DF.

Outpatient Services

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

- Office visits for adult and pediatric routine check-ups, well-baby care, and immunizations;
- Physician services in the Member's home, if the Member is too ill or disabled to be seen during regular working hours at the Physician's office. Member will pay the Copayment listed on the Copayment Schedule Attachment listed for Physician office visits for each such visit;
- Pre-natal and post-natal maternity care;
- Gynecological exams; annual pap and pelvic;
- Testing and treatment of PKU, includes formula and special food products that are medically necessary and prescribed for treatment of PKU;
- Surgical procedures;
- Periodic physical examinations;
- Office visits for consultations or care by a non-participating specialist when referred and authorized by WHA or its delegated Medical Group;
- Eye examinations, (including eye refractions);
- Hearing examinations;
- Laboratory, X-rays, electrocardiograms and all other tests determined to be Medically Necessary;
- Therapeutic injections, including allergy testing and shots;
- Health education and family planning services including counseling and examination;
- Outpatient Transgender Services — Outpatient Services including outpatient surgery services for transgender surgery, services related to the surgery, outpatient office visits, and related services, require prior authorization by WHA and are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member. WHA covers certain transgender surgery and services related to the surgery to change a Member's physical characteristics to those of the opposite gender.

Cancer Screenings

Includes, but is not limited to, all generally medically accepted cancer screening tests, an annual cervical cancer screening test, including a conventional Pap smear test and a human papillomavirus screening test that is approved by the federal Food and Drug Administration; upon referral by the Member's Physician, nurse practitioner, or certified nurse midwife, the option of any cervical cancer screening test approved by the Federal Food and Drug Administration; mammography screening or diagnostic; periodic prostate cancer screening including prostate-specific antigen testing; digital rectal examinations; fecal occult blood tests; and flexible sigmoidoscopy. Cancer screening is subject to all terms and conditions that would otherwise apply.

Cancer Clinical Trials

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

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

1. Drugs or devices associated with the clinical trial that have not been approved by the FDA;
2. Services other than health care services, such as travel or housing expenses, companion expenses, and other non-clinical expenses that a Member might incur as a result of the Member's participation in the clinical trial;
3. Any item or service provided solely for the purpose of data collection and analysis;
4. Health care services that are otherwise specifically excluded from coverage under the Member's plan; or
5. Health care services customarily provided by researchers free of charge to participants in the clinical trial.

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

Inpatient Services

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

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

- Semi-private room and board (private room when determined to be Medically Necessary by a Participating Provider);
- Physician's services including surgeons, and medical consultants;
- Hospital specialty services including the use of the operating room and the recovery room, anesthesia, inpatient drugs, X-ray, laboratory, radiation therapy and nursery care for newborns;
- Medical, surgical, and cardiac intensive care;
- Private-duty nurse when prescribed by a Participating Provider;
- Blood transfusion services; and
- Physical therapy, occupational therapy, and speech therapy, if required incident to an admission for Covered Services.

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

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

Rehabilitation Services

Outpatient

Short-term rehabilitative services including physical therapy, speech therapy, occupational therapy, respiratory therapy, cardiac rehabilitation and pulmonary rehabilitation are covered when authorized and determined to be Medically Necessary, and when therapy is determined to lead to continued improvement of the Member's condition.

Behavioral Health Services

Behavioral health services, including chemical dependency services, are not covered by WHA. They are covered through United Behavioral Health (UBH), the supplemental coverage provided by your employer (pending regulatory approval). You may reach UBH at (800) 440-8225.

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

Other Health Services

Home Health Care Services, short-term intermittent care, up to 100 visits per calendar year, when prescribed by a Participating Provider, and determined to be Medically Necessary. This benefit does not include meals, housekeeping, childcare, personal comfort or convenience items, services or supplies.

Hospice Care is covered when you have met the hospice care requirements:

- A Participating Physician has diagnosed you with a terminal illness and certifies, in writing, that your life expectancy is one year or less;
- A Participating Physician authorizes the services;
- A Participating Physician has written a plan of care;
- The services are to be provided by a licensed hospice agency approved by WHA or the Medical Group;
- The services are Medically Necessary for palliation or management of the terminal illness; and
- You elect Hospice care in writing.

If you elect Hospice Care, you are not entitled to any other services for the terminal illness under this EOC/DF. You may change your decision about Hospice Care at any time. The signed election statement and contracting Physician certification must accompany all hospice claims submitted for payment.

Under Hospice Care, we cover the following services and supplies when the above requirements are met:

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

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

Durable Medical Equipment (DME), Prosthetic Devices and Orthotic Devices when prescribed by a Participating Provider and determined to be Medically Necessary, covered

at a copayment set forth in the Copayment summary. Examples of DME include: standard wheelchair, oxygen and oxygen equipment. Orthotic devices include special footwear that is Medically Necessary as a result of foot disfigurement. Disfigurement includes: cerebral palsy, arthritis, polio, spina bifida, diabetes and accidental or developmental disabilities.

- WHA may, in its sole discretion, determine whether the covered device should be purchased or rented and directly order or coordinate the ordering of the covered device.
- Wheelchairs provided as a benefit under this health plan are limited to standard wheelchairs. A standard wheelchair is one that meets the minimum functional requirements of the Member.
- Where two or more alternative covered devices are appropriate to treat the Member's condition, the most cost-effective device will be covered.
- Coverage for covered devices is limited to the basic type of DME, Prosthetic Device or Orthotic Device that WHA determines to be necessary to provide for the Member's medical needs.
- The allowable cost of covered devices will not be applied toward similar services and supplies that are not covered devices.

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

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

Mastectomy and Reconstructive Breast Surgery to restore and achieve symmetry is covered in full. Coverage for a mastectomy shall include coverage for all complications from a mastectomy. This includes Medically Necessary physical therapy to treat the complications of mastectomy, including lymphedema; prosthetic devices; or reconstruction of the breast on which, the mastectomy is performed, including areolar reconstruction and the insertion of a breast implant. Reconstructive surgery for a healthy breast is also covered if, in the opinion of the attending Physician this surgery is necessary to achieve normal symmetrical appearance. The attending Physician consistent with sound clinical practice and in consultation with the patient will determine the length of the hospital stay for mastectomies and lymph node dissections.

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

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

Diabetes supplies, equipment, and services for the treatment and/or control of diabetes, are covered. Services include outpatient self-management training education and medical nutrition therapy for the treatment and/or control of diabetes necessary to enable you to properly use the equipment, supplies, and medications upon the direction or prescription of those services by your participating physician. The following equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin using

diabetes, and gestational diabetes are also covered as Medically Necessary, even if the items are available without a prescription:

1. Blood glucose monitors and blood glucose testing strips.
2. Blood glucose monitors designed to assist the visually impaired.
3. Insulin pumps and all related necessary supplies.
4. Ketone urine testing strips.
5. Lancets and lancet puncture devices.
6. Pen delivery systems for the administration of insulin.
7. Podiatric devices to prevent or treat diabetes-related complications.
8. Insulin syringes.
9. Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

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

1. Nebulizers, including face masks and tubing
2. Inhaler spacers
3. Peak flow meters

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

Emergency Medical Transport Services

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

Infertility services are covered including testing, consultations, examinations, diagnostic surgical services related to hospitalizations or facilities, and drug therapy. Services are covered at 50% of WHA's contracted rates when obtained with prior authorization. Copayments will vary by type of infertility service provided. We cover the following services:

1. Services and supplies for diagnosis and treatment of involuntary infertility.
2. Artificial insemination (except for donor semen or eggs, and services and supplies related to their procurement and storage), subject to a maximum of one treatment period of up to three (3) cycles per Lifetime.

Infertility Services Exclusions

All services and supplies (other than artificial insemination) related to conception by artificial means, such as, but not limited to:

1. In vitro fertilization (IVF).
2. Gamete Interfallopian Transfer (GIFT).
3. Ovum transplants.
4. Donor semen or eggs, and services and supplies related to their procurement and storage.
5. Zygote intrafallopian transfer (ZIFT).
6. Services and supplies to reverse voluntary, surgically induced infertility.

Prescription Medication Benefits

WHA shall cover prescription medications at participating pharmacies, prescribed in connection with a covered service and subject

to conditions, limitations and exclusions stated in this EOC/DF. Copayments for covered medications are described in the Copayment Summary. Copayments do not contribute to maximum out-of-pocket medical expenses.

The three-tier copay plan is not a closed formulary, but three different copays. Preferred Generic Medications listed on the Preferred Drug List (PDL) are covered at the lowest co-payment. Preferred Brand Name Medications listed on the PDL are provided at the second copayment level. Non-Preferred Medications are not listed on the PDL and are covered at the third tier copayment level, but generally do not require a prior authorization. There are a small number of drugs, regardless of tier level that may require Prior Authorization to ensure appropriate use based on criteria set by the WHA Pharmacy & Therapeutics (P&T) Committee. Members may request a copy of the PDL by calling (888) 563-2252 or view the document on the website: westernhealth.com.

Prescription drugs prescribed by a plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply. You pay $10 copay per prescription unit or refill for Preferred Generic Medications or $20 copay per prescription unit or refill for Preferred Brand Name Medications, and $35 copay per prescription unit or refill for Non-Preferred Medications per each 30-day supply or 120-unit supply, whichever is less. In no event will the copay exceed the cost of the Prescription Medication. If a Brand Name Medication is dispensed at the request of the physician or Member when a Generic Medication is available, the Member will pay the Preferred Generic Medication copay plus the difference in cost between the Generic Medication and the Brand Name Medication. If there is no Generic Medication equivalent, Preferred Brand Name or Non-Preferred Medication copay applies.

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

The initial prescription for maintenance medications is dispensed through a participating pharmacy (limited to a 30-day supply). Subsequent refills for a 90-day supply may be obtained through the Mail Order Program. You pay $20 copay for a 90-day supply of Preferred Generic Medication, $40 copay for a 90-day supply of Preferred Brand Name Medication, and $70 copay for a 90-day supply of Non-Preferred Medication through the Mail Order Program. In this way, you receive a 90-day supply of medication for only two retail pharmacy copays.

You may also obtain a 90-day supply from the UC Davis Medical Center Pharmacy; you pay $20 copay for Preferred Generic Medications, $40 for Preferred Brand Name Medications and $70 for Non-Preferred Medications.

Covered prescription medications include:

1. Oral medications that require a Prescription by state or federal law, written by a Participating Physician and dispensed by a Participating Pharmacy.
2. Covered Prescription medications dispensed by a non-Participating Pharmacy outside of WHA's service area for urgent or emergency care only. You may submit your receipt to Medco Health for reimbursement. To order claim forms call Medco Health Member Service at (800) 903-8664 or visit their website at: www.medcohealth.com.
3. Compounded Prescriptions which contain at least one Prescription ingredient.
4. Insulin and insulin syringes with needles and glucose test strips and tablets.
5. Oral contraceptives and diaphragms.

6. Prenatal Prescription vitamins or vitamins in conjunction with fluoride.
7. Oral medications for the treatment of Infertility and Erectile Dysfunction require copayments equal to 50% of the contracted prescription cost.

Prescription Exclusions and Limitations

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

1. Generic Medications are required. The pharmacist will automatically substitute equivalent Generic medication for the prescribed Brand Name medication (Preferred or Non-Preferred) unless your Physician writes, "do not substitute," or "prescribe as written,"; there is not a generic equivalent available; or the medication is included in the list of Narrow Therapeutic Index (NTI) drugs that currently have a potential equivalency issues. In these cases, the Member will be provided the Brand Name medication as written by the Member's Physician, even if a Generic is available. The Brand Name copayment will apply. A Member may request a list of applicable NTI drugs by calling WHA Member Services.
2. Some Prescription medications may require Prior Authorization by WHA. For clarification, please contact WHA Member Services at (916) 563-2252 or (888) 563-2252. Routine/non-urgent requests for prior authorization are processed within three business days if all applicable information is included with the request. Requests that are indicated as urgent will be reviewed within one business day. An incomplete request may delay the authorization process if the provider is not available to supply the necessary clinical information. WHA will notify you and your provider if it cannot process the authorization in a timely way due to lack of information and will specify the additional information that is necessary. For a Prior Authorization request after business hours or on weekends and holidays in an urgent or emergency situation the Pharmacy is authorized to dispense an emergency short supply of the medication.
3. Covered Prescription medications are limited to a 30 day supply at a participating pharmacy. A 90 day supply of oral Maintenance medications is available through WHA's Mail Order program (see item 4). Prescriptions for controlled substances and other drugs not intended for continuous use may be limited to a smaller quantity per Copayment.
4. Covered Prescription Medications that are to be taken beyond 60 days are considered Maintenance medications and may be obtained through the Mail Order Program. The initial Prescription for Maintenance medications may be dispensed through a Participating Pharmacy (limited to a 30 day supply). Subsequent refills for a 90 day supply may be obtained through the Mail Order program.
5. Over-the-counter medications or medications that do not require a Prescription are excluded (except for insulin and insulin syringes with needles for diabetics).
6. Medications that are not Medically Necessary are excluded.
7. Treatment of impotence and/or sexual dysfunction must be medically necessary and documentation of a confirmed diagnosis of erectile dysfunction must be submitted to the Plan for review. Drugs and medications are limited to eight (8) pills per month for a 30-day period and are subject to a 50% copayment.
8. Medications that are experimental or investigational are excluded, except life-threatening or Seriously Debilitating conditions and cancer clinical trials as described in the EOC/DF, under the section titled, "Appeal for Investigational/ Experimental Treatment".
9. There are a small number of drugs, regardless of PDL tier level, that may

require prior authorization for a non-FDA approved indication (off label use). For off label use, the medication must be FDA approved for some indication and recognized by the AMA Drug Evaluations, the American Hospital Formulary Service Drug Information, the United States Pharmacopoeia Dispensing Information (vol. I, Drug Information for the Health Care Professional) or at least two articles from major peer reviewed medical journals that present data supporting the proposed use as safe and effective, unless there is clear and convincing contradictory evidence in a similar journal.

10. Prescriptions written by dentists are excluded.
11. Drugs required for foreign travel are excluded, unless they are prior authorized for Medical Necessity.
12. Prescription products for cosmetic indications, including agents for wrinkles or hair growth and over-the-counter dietary/nutritional aids and health/beauty aids are excluded.
13. Drugs used for weight loss and dietary/ nutritional aids which require a prescription are excluded, unless they are prior authorized for Medical Necessity.
14. Contraceptive devices (including IUD's) and implantable contraceptives, are not covered under the pharmacy benefit; they are covered under the medical benefit as described in this EOC/DF, in the Principal Benefits and Covered Services section.
15. Medication for injection or implantation (except insulin and other medications as determined by WHA) are covered under the medical benefit as described in this EOC/DF under the sections titled "Outpatient Services" and "Diabetes supplies, equipment and services".
16. Pharmacies which dispense covered Prescription medications to Members pursuant to the Agreement and this EOC/DF do so as independent contractors. WHA shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with any injuries suffered by Members.
17. WHA shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with the manufacturing, compounding, dispensing, or use of any covered Prescription Medication.
18. Vitamins (except prenatal prescription vitamins or vitamins in conjunction with fluoride) are excluded.
19. Medications for the treatment of short stature, unless medically necessary.
20. Replacement medications for drugs that are lost or stolen are not covered.

Submitting Prescription Claims for Reimbursement

If you have to pay for covered Prescription Medications as described in this EOC/DF, submit your receipt to Medco Health for reimbursement. To order claim forms call Medco Health Member Service at (800) 903-8664 or visit their website at: www.medcohealth.com. The claim should be submitted to Medco Health within 60 days of purchase. No claim will be considered if submitted after 12 months from the date of purchase.

Principal Exclusions and Limitations

The following Services and Supplies are excluded or limited:

Exclusions

1. Any services or supplies obtained before the Member's effective date of coverage.
2. Services and supplies, which are not Medically Necessary. If a service is denied or is not covered based on Medical Necessity, a Member may appeal the decision through the Independent Medical Review (IMR) process found in the Section of this EOC/DF titled "Member Satisfaction Procedure" and "Independent Medical Review."
3. Non-emergent services and supplies rendered by non-Participating Providers without written referral by the Member's PCP. Care by non-Participating Providers will only be provided as a Covered Service if the care is determined to be Medically Necessary and not available through Participating Providers.
4. Experimental medical or surgical procedures, services or supplies. Please refer to the Section of this EOC/DF titled "Member Satisfaction Procedure" and "Appeal for Investigational/Experimental Treatment."
5. Long term care benefits including skilled nursing care and respite care, are excluded except for Medically Necessary Covered Services described in the "Principal Benefits and Covered Services" section under "Other Health Services" "Hospice Care."
6. Cosmetic services and supplies, except for Prosthetic Devices incident to a mastectomy or laryngectomy or reconstructive surgery necessary to repair a functional disorder as a result of disease, injury, or congenital anomaly, or to improve function and/or create a normal appearance, to the extent possible. The exclusion includes services and supplies performed in connection with the reformation of sagging skin; the enlargement, reduction or change in the appearance of a portion of the body; hair transplant or analysis; chemical face peels or abrasions of the skin.
7. Penile Prostheses are excluded unless prescribed by a Participating Physician and determined to be both Medically Necessary (e.g., secondary to penile trauma, tumor, or physical disease to the circulatory system or nerve supply), and not of a psychological cause.
8. Non-emergent medical transport or ambulance care inside or outside the Service Area, except with Prior Authorization.
9. Vision therapy, eyeglasses, contact lenses and surgical procedures for the correction of visual acuity in lieu of eyeglasses or contact lenses (except for intraocular lenses in connection with cataract removal).
10. Hearing aid batteries.
11. Services or supplies in connection with the storage of body parts, fluids or tissues, except for autologous blood.
12. Dental care, except for (1) non-dental surgical and hospitalization procedures incidental to facial fractures, tumors or congenital defects, such as cleft lip or cleft palate, or (2) Surgery on the maxilla or mandible that is Medically Necessary to correct temporomandibular joint disease (TMJ) or other medical conditions, when Medically Necessary and Prior Authorized. Other dental services excluded include:
    - Items or services in connection with the care, treatment, filling, removal, replacement, or artificial restoration of the teeth or structures directly supporting the teeth.
    - Treatment of dental abscesses, braces, bridges, dental plates, dental prostheses and dental orthoses, including anesthetic agents or drugs used for the purpose of dental care.

13. Any services or supplies provided by a person who lives in the Member's home, or by an immediate relative of the Member.
14. Personal comfort or convenience items (e.g., television, radio), home or automobile modifications, or improvements (e.g., chair lifts, purifiers).
15. Vitamins except prenatal prescription vitamins or vitamins in conjunction with fluoride.
16. Routine foot care (e.g., treatment of or to the feet for corns or calluses), except when Medically Necessary. Orthotic Devices for routine foot care are also excluded. This exclusion does not apply to special footwear required as a result of foot disfigurement caused by diabetes.
17. Chiropractic services, acupuncture, acupressure, biofeedback, sex therapy, dance therapy and recreational therapy.
18. All immunizations required by an employer as a condition of employment.
19. Services and supplies to reverse voluntary, surgically induced infertility. Embryo transfers and any services and supplies related to donor sperm or sperm preservation for artificial insemination, are excluded, including all services involved in surrogacy. All services and supplies (other than artificial insemination) related to conception by artificial means, such as, but not limited to:
    - In vitro fertilization (IVF).
    - Gamete Interfallopian Transfer (GIFT).
    - Ovum transplants.
    - Donor semen or eggs, and services and supplies related to their procurement and storage.
    - Zygote intrafallopian transfer (ZIFT).
    - Services and supplies in connection with the reversal of voluntary sterilization are excluded.
20. Surrogacy, which is pregnancy under a surrogate arrangement. A surrogate pregnancy is one in which a woman has agreed to become pregnant with the intention of surrendering custody of the child to another person. If the surrogate is a Member of WHA, she is entitled to maternity services, but in the event pregnancy services are rendered to a woman in a surrogate arrangement, the Plan has the right to impose a lien against any amount received by the surrogate/ Member for reasonable costs incurred by WHA.
21. Home birth delivery.
22. Custodial care or services and supplies furnished by an institution which is primarily a place for rest and provides primarily non-nursing supervision of the patient. Other excluded services include homemaker services and convalescent care. This exclusion does not apply to Covered Services included in the Hospice benefit described under the "Principal Benefits and Covered Services" section of this EOC/DF.
23. Non-prescription weight loss aids and programs and non-participating provider programs.
24. Smoking cessation products and programs.
25. Repair and replacement of DME, Orthotics or Prosthetics when necessitated by the Member's abuse, misuse or loss. Any device not medical in nature (e.g., exercise equipment, whirlpool, spa), more than one device for the same body part, or more than one piece of equipment that serves the same function.
26. Food supplements or infant formulas, except in the treatment of PKU.
27. Over-the-counter supplies or equipment that may be obtained without a prescription except for diabetes and pediatric asthma supplies as described under the headings "Diabetes supplies, equipment and services" and "Pediatric Asthma supplies, equipment, and services".

28. Services and supplies associated with the donation of organs where the recipient is not a member of WHA. Medically Necessary services for the treatment of organ transplants where the Member is the organ recipient are covered (see "Transplants").
29. Court-ordered health care services and supplies when not Medically Necessary.
30. Travel expenses, including room and board, even if the purpose is to obtain a Covered Service, except for Transgender Surgery, (see Inpatient Transgender Surgery for limitations).
31. Expenses incurred obtaining copies of the medical records if requested by the Member for personal use.
32. Weight control surgery or procedures including without limitation gastric bubble, gastroplasty, gastric bypass, gastric stapling, liposuction and HCG injections; and any Experimental Procedures for the treatment of obesity. However, Medically Necessary services as determined by WHA for the treatment of morbid obesity with a Prior Authorization are covered.
33. Testing for the sole purpose of determining paternity.
34. Diagnostic procedures or testing for genetic disorders, except for prenatal diagnosis of fetal genetic disorders in cases of high-risk pregnancy or when medically indicated.
35. Diagnosis and treatment for personal growth and/or development, for personality reorganization or in conjunction with professional certification.
36. Marriage counseling.
37. Ancillary services such as vocational rehabilitation, behavioral training, sleep therapy, employment counseling, training or education therapy for learning disabilities or other Educational Services.
38. Psychological examination: testing or treatment for purposes of licensing or insurance, judicial or administrative proceedings (including but not limited to parole or probation proceedings), or satisfying an employer's, prospective employer's or other party's requirements for obtaining employment.
39. Psychological testing, except when Medically Necessary.
40. Mental health treatment of obesity or weight reduction (except in connection with anorexia nervosa or bulimia), including supplies.
41. Stress management therapy.
42. Aversion therapy.
43. Mental health treatment of pain, except for Medically Necessary treatment of pain with psychological or psychosomatic origins.
44. Treatment of short stature unless Medically Necessary.
45. Exclusions related to transgender surgery services:
    - Liposuction to reshape waist, hips, thighs and buttocks;
    - Cosmetic chest reconstruction or augmentation mammoplasty;
    - Electrolysis and laser hair removal, except when required as part of covered transgender genital reconstruction surgery;
    - Drugs for hair loss or growth;
    - Voice therapy or voice modification surgery;
    - Sperm or gamete procurement for future infertility or storage of sperm, gametes or embryos;
    - Penile implant devices, penile device implantation, and penile implant revision or reinsertion;
    - Intersex surgery (transsexual operations) except as specifically provided under the "Inpatient Transgender Surgery" and "Outpatient Transgender Services" sections of the "Principal Benefits and Covered Services" section or treatment of any

resulting complications, unless that treatment is determined to be medically necessary.

Limitations

All benefits for Covered Services are provided in connection with determining Medical Necessity. The services and supplies used to diagnose and treat any disease, illness or injury must be used in accordance with professionally recognized standards of practice.

1. Services and supplies rendered by non-Participating Providers are covered for Urgent Care and Emergency Care only, or when care from the non-Participating Provider has been authorized in advance.
2. Physical, speech, and occupational therapy and cardiac and pulmonary rehabilitation are limited to short-term rehabilitation services, unless additional care is Medically Necessary. Therapy and rehabilitation are not covered when:
   - Medical documentation does not support the medical necessity because of the Member's inability to progress toward the treatment plan goals; or
   - A Member has already met the treatment plan goals.
3. Physical exams, and/or laboratory, X-ray or other diagnostic tests ordered in conjunction with a physical exam will not be a covered benefit if the purpose of the test is exclusively to fulfill an employment, licensing, sports, or school related requirement.
4. If services or supplies are received while a Member is entitled to 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, the Member is required to assist in the assignment, liens and recovery of any WHA expense; WHA may file a lien on any proceeds received by a Member 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. See "Third Party Responsibility — Subrogation".
5. WHA will not be held liable for the lack of available services in the event of a major disaster, epidemic, war, and riot or other like circumstances beyond the control of WHA, which renders a Participating Provider unable to provide services. However, Participating Providers will provide or attempt to arrange for Covered Services according to their best judgment within the limitations of available facilities or personnel. If the Plan is unable to provide services it will refer Members to the nearest hospital for Emergency services and later provide reimbursement to the Member for such Covered Services.
6. For Covered Services, WHA reserves the right to coordinate your care in a cost effective and efficient manner.
7. Private hospital rooms and/or private duty nursing unless determined to be Medically Necessary and authorized by WHA.
8. WHA covers certain transgender surgery and services related to the surgery to change a Member's physical characteristics to those of the opposite gender. Inpatient and Outpatient Services for transgender surgery and services related to the surgery require prior authorization by WHA and are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member.

Eligibility, Enrollment, and Termination

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

ELIGIBILITY

The following individuals are eligible to enroll in the WHA Plan described in this EOC/DF. If the Plan is a Health Maintenance Organization (HMO) or Exclusive Provider Organization (EPO) Plan, they are only eligible to enroll in the Plan if they meet the Plan's geographic Service Area criteria. Anyone enrolled in a non-University Medicare Advantage Managed Care contract or enrolled in a non-University Medicare Part D Prescription Drug Plan will be disenrolled from this WHA plan.

To be eligible to enroll with WHA:

- All subscribers and dependents must live or work within a WHA licensed zip code, meaning that either their primary workplace or Primary Residence is within a WHA licensed zip code. See "WHA Service Area Zip Code List" at the end of this EOC/DF.

Subscriber

Employee

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

*Lecturers — see your benefits office for eligibility.

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

Retiree

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

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

a. You meet the University's service credit requirements for Retiree medical eligibility;

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

c. You elect to continue medical coverage at the time of retirement.

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

If you are eligible for Medicare, you must follow UC's Medicare Rules. See "Effect of Medicare on Retiree Enrollment" below.

Eligible Dependents (Family Members)

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

Spouse: Your legal spouse.

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

a. Your natural or legally adopted children;

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

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

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

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

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

Application must be made to WHA at least 31 days before the child's 23rd birthday and is subject to approval by WHA. WHA 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 twenty-three (23), and you must apply for University coverage during your Period of Initial Eligibility.

Other Eligible Dependents (Family Members)

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

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

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

No Dual Coverage

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

More Information

For information on who qualifies and how to enroll, contact your local Benefits Office or the University of California's Customer Service Center. You may also access eligibility fact sheets on the website: atyourservice.ucop.edu.

ENROLLMENT

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

During a Period of Initial Eligibility (PIE)

A PIE ends 31 days after it begins.

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

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

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

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

c. For an adopted child, the earlier of:

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

    ii. The date the child is placed in your physical custody.

d. 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.

e. 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 (or if the employer stops contributing toward the other coverage for you or your Family Members), you may be able to enroll yourself and those eligible Family Members during a PIE that starts on the day the other coverage is no longer in effect.

If you are in an HMO, POS or EPO Plan and you move or are transferred out of that Plan's

Service Area, or will be away from the Plan's Service Area for more than two months, you will have a PIE to enroll yourself and your eligible Family Members in another University medical plan. Your PIE starts with the effective date of the move or the date you leave the Plan's Service Area.

At Other Times for Employees and Retirees

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

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

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

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

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

If you are an Employee or a Retiree and there is a lifetime maximum for all benefits under this plan, and you or a Family Member reaches that maximum, you and your eligible Family Members may be eligible to enroll in another UC-sponsored medical plan. Contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree). (If this Plan is an HMO, there is no lifetime maximum for all benefits.)

If you are a Retiree, you may continue coverage for yourself and your enrolled Family Members in the same plan (or its Medicare version) you were enrolled in immediately before retiring.

You must elect to continue enrollment for yourself and enrolled Family Members before the effective date of retirement (or the date disability or survivor benefits begin).

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

Effective Date

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

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

Change in Coverage

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

Effect of Medicare on Retiree Enrollment

If you are a Retiree and you and/or an enrolled Family Member is or becomes eligible for premium-free Medicare Part A (Hospital Insurance) as primary coverage, then that individual must also enroll in and remain in Medicare Part B (Medical Insurance). Once Medicare coverage is established, coverage in both Part A and Part B must be continuous. This includes anyone who is entitled to Medicare benefits through their own or their spouse's employment. Individuals enrolled in both Part A and Part B are then eligible for the Medicare premium applicable to this plan.

Retirees or their Family Member(s) who become eligible for premium-free Medicare Part A on or after January 1, 2004 and do not enroll in Part B will permanently lose their UC-sponsored medical coverage.

Retirees and their Family Members who were eligible for premium-free Medicare Part A prior to January 1, 2004, but declined to enroll in Part B of Medicare, are assessed a monthly offset fee by the University to cover increased costs. The offset fee may increase annually, but will stop when the Retiree or Family Member becomes covered under Part B.

Retirees or Family Members who are not eligible for premium-free Part A will not be required to enroll in Part B, they will not be assessed an offset fee, nor will they lose their UC-sponsored medical coverage. Documentation attesting to their ineligibility for Medicare Part A will be required. (Retirees/ Family Members who are not entitled to Social Security and premium-free Medicare Part A will not be required to enroll in Part B.)

An exception to the above rules applies to Retirees or Family Members in the following categories who will be eligible for the non-Medicare premium applicable to this plan and will also be eligible for the benefits of this plan without regard to Medicare:

a. Individuals who were eligible for premium-free Part A, but not enrolled in Medicare Part B prior to July 1, 1991.
b. Individuals who are not eligible for premium-free Part A.

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

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

Any individual enrolled in a University-sponsored Medicare Advantage Managed Care Contract must assign his/her Medicare benefit to that plan or lose UC-sponsored medical coverage. Anyone enrolled in a non-University Medicare Advantage Managed Care contract or enrolled in a non-University Medicare Part D Prescription Drug Plan will be disenrolled from the WHA Plan described in this EOC/DF.

Medicare Secondary Payer Law (MSP)

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

becomes the secondary payer and the employer plan becomes the primary payer. You should carefully consider the impact on your health benefits and premiums should you decide to return to work after you retire.

Medicare Private Contracting Provision and Providers Who Do Not Accept Medicare

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. These private agreements will require the beneficiary to be responsible for all payments to such medical providers. Since services provided under such "private contracts" are not covered by Medicare or WHA, the Medicare limiting charge will not apply. The "limiting charge" is the charge approved by Medicare for participating physicians or practitioners.

Some physicians or practitioners have **never** participated in Medicare. Their services (that would be covered by Medicare if they participated) will not be covered by Medicare or WHA, and the Medicare limiting charge (see definition above) will not apply.

If you are classified as a Retiree by the University (or otherwise have Medicare as a primary coverage), are enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement as described above with one or more physicians or practitioners, or if you choose to obtain services from a provider who does not participate in Medicare, under the law you have in effect "opted out" of Medicare for the services provided by these physicians or other practitioners. In either case, no benefits will be paid by WHA 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. Therefore, it is important that you confirm that your provider takes Medicare prior to obtaining services for which you wish WHA to pay.

However, even if you do sign a private contract or obtain services from a provider who does not participate in Medicare, you may still see **other** providers who have not opted out of Medicare and receive the benefits of this Plan for those services.

TERMINATION OF COVERAGE

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

Disenrollment Due to Loss of Eligible Status

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

Disenrollment Due to Fraud

Coverage for you or your Family Members may be terminated for fraud or deception in the use of the services of WHA, 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 WHA). A Family Member who commits fraud or deception will be permanently disenrolled while any other Family Member and the Subscriber will be

disenrolled for 12 months. If a Subscriber commits fraud or deception, the Subscriber and any Family Members will be disenrolled for twelve (12) months.

Leave of Absence, Layoff or Retirement

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

Individual Continuation of Benefits

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

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

Optional Continuation of Coverage (COBRA & Cal-COBRA)

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

Introduction to COBRA and Cal-COBRA

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

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

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

Under both COBRA and Cal-COBRA, all benefits you receive under continuation coverage are the same as the benefits available to active eligible employees and their eligible dependents. If coverage is modified for active eligible employees and their eligible dependents, it will be modified in the same manner for you and all other Qualified Beneficiaries. In that case, an appropriate adjustment in the premium for continuation

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

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

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

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

COBRA Benefits

Your Right to Elect Continuation Coverage

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

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

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

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

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

In the case of your Eligible Dependent Spouse

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

1. Your death; or
2. The termination of your employment for a reason other than your gross misconduct, or the reduction of your work hours (including approved leave without pay or layoff); or
3. Your divorce or legal separation from your spouse, or the annulment of your marriage; or
4. You become entitled to Medicare benefits; or
5. A dependent enrolled in your group benefit plan loses dependent status.

In the case of your Eligible Dependent Child

Your child may continue coverage for himself or herself if your child's coverage would have ended because of any of the following Qualifying Events:

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

Cal-COBRA Benefits

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

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

Multiple Qualifying Events

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

Exclusions from Cal-COBRA

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

COBRA and Cal-COBRA Eligibility and Premium Payments

Electing COBRA and Cal-COBRA Continuation Coverage

You elect continuation coverage under COBRA and Cal-COBRA in the same way, although the rates for COBRA and Cal-COBRA may be different. Once you have made Western Health Advantage or your Employer aware of a Qualifying Event, you will be given a form with which to elect continuation coverage. The form will advise you of the amount of premium required for the continuation coverage. (See below for premium limits.) Please follow the directions on the form to elect continuation coverage. Send the form to the following address, unless directed otherwise on the form:

Western Health Advantage
Attn: COBRA Enrollment Department
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833-9754
(916) 563-2252 or (888) 563-2252

The form must be delivered by first class mail, overnight courier or some other reliable means of delivery. Personal delivery is also acceptable. Please remember that the form must be completed and returned to the address above, within sixty (60) days of the later of: (1) the date of the Qualifying Event; or (2) the date you received notice informing you of the right to elect continuation coverage. *Failure to return the form within the sixty (60) day time limit will disqualify you from participating in Cal-COBRA continuation coverage*.

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

Termination of COBRA/Cal-COBRA Continuation Coverage

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

Normal Period of COBRA Continuation Coverage

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

Normal Period of Cal-COBRA Continuation Coverage

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

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

If your employer’s group health plan with Western Health Advantage terminates before your continuation coverage expires, you may nevertheless maintain your coverage for the balance of your continuation period as if the group health plan had not terminated, so long as, within thirty (30) days of your receipt of

notice of the termination, you comply with any requirements that may be imposed regarding enrollment and payment of premiums resulting from the termination. Failure to comply with applicable enrollment and premium requirements will cause your continuation coverage to end.

Premature Termination of COBRA or Cal-COBRA

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

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

Cost of Continuation Coverage under COBRA and Cal-COBRA

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

Health Insurance Portability and Accountability Act (HIPAA)

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

If subscribers or dependents have questions concerning HIPAA, they may contact Office of Civil rights at (866) 627-7748 or at the following Internet address: www.hhs.gov/ocr/hipaa/.

To the extent that the provisions of the group contract and EOC/DF do not comply with any provision of the HIPAA of 1996, they are hereby amended to comply.

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

Renewal Provisions

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

Conversion Option

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

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

Termination of Benefits

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

Reasons for Termination

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

- You fail to pay the required Copayments to any Participating Provider for services rendered after being properly notified and billed. If the Member who are unwilling to make payment arrangements within forty-five (45) days of the date payment is due, or fail to comply with such arrangements when made, will be mailed a notice of cancellation. Termination will be effective fifteen (15) days after the date the notice was mailed, as stated in the notice, as specified in the notice of cancellation.
- You provide incorrect or misleading information that is material, or you intentionally omit material information that pertains to you and/or your families' receipt of "healthcare services". Termination shall be effective upon the mailing of written notice by WHA to the Subscriber and Employer.
- You seek and/or obtain medications under false pretenses to support a drug dependency or for the illegal sale of the medications.
- You threaten the safety of Plan employees, or providers, members, or other patients: or your repeated behavior has substantially impaired the Plan's ability to furnish or arrange services for you or other members, or a provider's ability to provide services to other patients.
- If a Subscriber no longer works or maintains a permanent Primary Residence within the Service Area, coverage will be terminated for the Subscriber and any

enrolled Family Members effective midnight of the last day of the month in which such event occurred. However, coverage may be continued for a Subscriber and any enrolled Family Members if the Subscriber is temporarily assigned by the Employer to work or study outside of the Service Area. In this case the Subscriber must maintain a Primary Residence within the Service Area, and the temporary residency outside the Service Area must not continue beyond four (4) months. Coverage may also be continued for any Family Member who is a registered, full-time student at an accredited college or university outside the Service Area as long as the Subscriber either works or maintains a Primary Residence within the Service Area. In such cases, coverage for services received outside the Service Area shall be limited to Urgent or Emergency Care. All non-Urgent care and non-Emergency Care services must be provided by Participating Providers within the Service Area in order to be covered under this Health Plan.

- You make a false statement, misrepresentation or omission in the application and enrollment forms, a response to a subordination request from WHA, or any other correspondence or communication with WHA, including but not limited to misrepresentations regarding a Member's health history or a Member's eligibility for membership, which is/are material; you intentionally omit information regarding a Member's health history or a Member's eligibility for membership; you obtain or attempt to obtain Covered Services by means of material, false statements, material misrepresentations or intentional omissions; you permit any other person to use a Member's identification card to obtain services under this Health Plan or otherwise misuse your identification card; or you engage in any fraudulent conduct. In any of these cases, WHA may terminate coverage immediately upon written notice.
- Loss of eligibility under the terms of this EOC/DF.

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

Termination of Group Contract

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

Exception to Cancellation of Group Benefits

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

- You are or your enrolled Family Member is a registered bed patient in a hospital at the date of termination. You or your dependent will continue to receive all benefits of coverage for the condition confining you to the hospital, subject to the prepayment fees and applicable copayments, until those benefits expire or you are discharged from the hospital, whichever occurs first.
- You are or your enrolled Family Member is receiving inpatient obstetrical care at the date of termination and there has been no default in prepayment fees. Inpatient obstetrical care will continue only through discharge.
- You are Totally Disabled by a condition for which you are receiving covered benefits. WHA will continue to maintain full coverage during the disabling condition for collection of the full monthly premium. Coverage will end (1) at the close of the twelfth (12^{th}) month following termination, (2) when it is determined you are no longer disabled, or (3) when you are covered under a

replacement agreement or policy without limitations as to the disability condition, whichever occurs first.

Effective Date of Termination of Coverage

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

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

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

Once Medical Plan coverage as a Retiree is cancelled, coverage cannot be reinstated.

Refunds and Review of Termination

If your coverage terminates, payment of premiums for any period after the termination date and any other amounts due to you will be refunded to your employer within thirty (30) days, minus any amount due to WHA. Exceptions include termination by WHA for fraud or deception in the use of health services or facilities or knowingly permitting such fraud or deception by another.

If you believe your Membership was terminated improperly by WHA, you may request a review of the termination by the California Department of Managed Healthcare.

Plan Administration

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

This section describes how WHA 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
Health & Welfare Administration
300 Lakeside Drive, 12th Floor
Oakland, CA 94612
(800) 888-8267

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

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

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

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

Group Contract Number

The Group Contract Number for this Plan is: 001021

Type of Plan

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

Plan Year

The plan year is January 1 through December 31.

Continuation of the Plan

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

Financial Arrangements

The benefits under the Plan are provided by Western Health Advantage, under a Group Contract. The plan costs are currently shared between you and the University of California.

Agent for Serving of Legal Process

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

Your Rights under the Plan

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

- Examine, without charge, at the Plan Administrator's office and other specified sites, all Plan documents, including the Group Contract, at a time and location mutually convenient to the participant and the Plan Administrator.
- Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

Claims under the Plan

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

Nondiscrimination Statement

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

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

Financial Considerations

Prepayment Fees

Your employer is responsible for prepayment of monthly premiums for WHA coverage. You will be notified by your employer if you are required to pay a portion of these charges. Health services are covered only for Members whose prepayment fees have been received by WHA and coverage extends only through the period for which such payment is received.

Other Charges — Copayments

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

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

Reimbursement Provisions

If, in an Emergency, you have to use non-participating hospitals or Physicians, WHA will reimburse you for charges or will arrange to pay the providers directly, minus applicable Copayments. Request for reimbursement must be submitted within one hundred eighty (180) days of the date services were rendered with proof of payment enclosed. If you need to submit a claim, contact Member Services at (916) 563-2252 or (888) 563-2252 to find out where and how to submit it.

Out-of-Pocket Maximum Liability

The annual out-of-pocket maximum liability (OOP) for Members under this Plan, per calendar year, is limited to $1,000 for an individual and $3,000 for a family of two or more. Except as set forth below, the Copayments you pay during the calendar year will be applied to the OOP. When you pay a Copayment for Covered Services, ask for and keep the receipt. When the receipts add up to the amount of the annual OOP, submit your receipts to WHA. Please call our Member Services Department to find out where to submit your receipts. After you submit your receipts showing that you have met the OOP, WHA will provide you with a document that shows you do not have to pay any Copayments for Covered Services through the end of the calendar year.

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

- Prescription Drug Copayments, which includes oral and injectable medications
- Infertility benefits

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

Coordination of Benefits

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

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

Third Party Responsibility — Subrogation

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

1. Each Member or Representative will promptly notify WHA of the name and address of the third party, the name of any involved attorneys, a description of any involved insurance policies, coverages and adjusters, and the circumstances which caused the injury or death; and will provide copies of any pertinent reports or related documents;
2. Each Member or Representative will execute and deliver to WHA any and all lien authorizations, assignments, releases or other documents requested by WHA, which may be needed to fully and completely protect the legal rights of WHA;
3. Immediately upon receiving any Recovery, the Member or Representative will notify WHA and will reimburse WHA for the value of the services and benefits provided, as set forth below. Any such Recovery by or on behalf of the Member and/or Representative will be held in trust for the benefit of WHA and will not be used or disbursed for any other purpose without WHA's express prior written consent. If the Member and/or Representative receive any Recovery which does not specifically include an award for medical costs, WHA will nevertheless have a lien against such Recovery; and
4. Any Recovery received by the Member or Representative shall first be applied to reimburse WHA for Covered Services provided and/or paid, regardless of whether the total amount of Recovery is less than the actual losses and damages incurred by the Member and/or Representative.

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

"Recovery" refers to any compensation received from a judgment, decision, award, insurance payment, or settlement in connection with a civil, criminal or administrative claim, complaint, lawsuit, arbitration, mediation, grievance or proceeding which arises from the act or omission of a third-party.

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

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

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

value of the lien, and prior to any other reductions.

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

Non-Duplication of Benefits

In the event that you are entitled to benefits under any of the government programs listed below, WHA's liability for services will be reduced by the amount of benefits paid by the government program, or by the lesser of the reasonable value of the services or the amount of WHA's fee-for-service payment to the provider for the services provided without any cost to you because of your entitlement to such benefits. This exclusion is applicable to benefits received from any of the following sources:

1. Benefits provided under Title XVIII of the Social Security Act ("Medicare"). This exclusion for Medicare does not apply when the employer is subject to the Medicare Secondary Payer laws and the employer maintains:

   A. An employer group health plan that covers:

      (1) Persons entitled to Medicare solely because of end-stage renal disease, and

      (2) Active employees or spouses or Domestic Partners entitled to Medicare by reason of age, and/or

   B. A large group health plan, as defined under the Medicare Secondary Payer laws that covers persons entitled to Medicare by reason of disability.

      This paragraph also applies to a Medicare-eligible Subscriber or Dependent on the date that he or she received notice from WHA of eligibility for such enrollment.

2. Benefits provided by any other federal or state governmental agency, or by any county or other political subdivision. This exclusion does not apply to Medi-Cal; Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code; or for the reasonable costs of services provided to the person at a Veterans' Administration facility for a condition unrelated to military service or at a Department of Defense facility, provided the person is not on active duty.

By enrolling, you agree to submit the necessary documents requested by WHA to assist in recovering the maximum value of services you receive under the above government programs. If you fail to submit documents reasonably requested by WHA, you must pay for services received at prevailing rates.

Other Limitations on Coverage

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

Member Satisfaction Procedure

WHA strives to provide exceptional health care services to you. However, if you have a concern about your medical care, you should discuss it with your PCP. If you need help answering your questions, clarifying procedures, submitting a claim, or investigating complaints, call Member Services between 8 a.m. and 5 p.m. Monday through Friday, at (916) 563-2252 or (888) 563-2252. If you prefer, you can visit or write to:

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

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

Appeal and Grievance Procedure

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

Western Health Advantage
Attn: Appeals Department
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833
(916) 563-2252 or (888) 563-2252

Please include a complete discussion of your questions or situation and your reasons for dissatisfaction and submit the appeal or grievance to WHA Member Services within one hundred eighty (180) days of the incident or action that caused your dissatisfaction. If you are unable to meet this period, please contact Member Services on how to proceed.

WHA sends an acknowledgment letter to the Member within five (5) calendar 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's Medical Management Department, 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 and a description of the grievance procedures is available at every Medical Group and Plan facility and on WHA's website. In addition, a Complaint Form will be promptly sent to you if 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 thirty (30) days of receipt. Written notification of the disposition of the appeal will be sent to the member and will include an explanation of the contractual or clinical rationale for the decision. Contact Member Services for more detailed information about the appeals and grievance procedure.

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (916) 563-2252 and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than thirty (30) days, you may call the department for assistance. You may also be

eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (888) HMO-2219 ((888) 466-2219) and a TDD line (877) 688-9891 for the hearing and speech impaired. The department's Web site, www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

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

Grievances related to Behavioral Health or Chemical Dependency Detoxification Benefits

For any complaints regarding behavioral health and chemical dependency services, please contact United Behavioral Health, your behavioral health and chemical dependency carrier at (800) 424-1778. If you believe that UBH is not providing these services at the same level as your medical benefits, including the same copayments and deductibles, please contact WHA at the phone numbers above under "Appeal and Grievance Procedure," or contact the DMHC as described above.

Expedited Appeal Review

An expedited appeal is a request by the Member, by a practitioner on behalf of the Member or by representative for the Member requesting reconsideration of a denial of services which requires that a review and determination be completed within 72-hours as the treatment requested may be addressing severe pain or 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 request in person or by telephone from the Member, a practitioner on behalf of the Member or a representative of the Member. To request an expedited appeal via telephone, please call Member Services at (916) 563-2252 or (888) 563-2252. The request is logged and all necessary information is collected in order to review and render a decision. You will be notified of your right to immediately contact the Department of Managed Health Care and that it is not necessary to participate in WHA's grievance process prior to applying to the Department of Managed Health Care for review of an urgent grievance.

If WHA determines that a delay of the requested review would result in severe pain or would compromise the Member's life or health, the appeal is then reviewed under expedited conditions.

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

Independent Medical Review (IMR)

Members may seek an Independent Medical Review (IMR) through the Department of Managed Healthcare (DMHC) whenever covered health care services have been denied, modified, or delayed by WHA, its contracting Medical Groups or its Participating Providers, if the decision was based in whole or in part on findings that the proposed services were not Medically Necessary. A decision regarding a Disputed Health Care Service relates to the practice of medicine and is not a Coverage

Decision. All Disputed Health Care Services are eligible for an IMR if the following requirements are met:

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

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

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

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

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

There is no application or processing fee required.

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

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

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

Independent Medical Review of Investigational/Experimental Treatment

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

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

The written request can be submitted to the Plan at:

Western Health Advantage
Attn: Appeals Department
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833
(888) 563-2252

A WHA Member has the right to request an Independent Medical Review when coverage is denied as an Experimental or Investigational Procedure and the Member's Physician certifies that the Member has a terminal condition for which standard therapies are not or have not been effective in improving the Member's condition, or would not be medically appropriate for the Member; or that there is no more beneficial standard therapy covered by WHA than the therapy recommended pursuant the following:

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

If a Member with a Life Threatening or Seriously Debilitating Condition who meets the criteria above disagrees with the denial of a service, medication, device or procedure deemed to be experimental, he/she may request a review by outside medical experts. This request can be made verbally or in writing. The Member may also request a face-to-face meeting with WHA's Chief Medical Officer to discuss the case. WHA will gather all medical records and necessary documentation relevant to the patient's condition and will forward all information to an external independent reviewer within five (5) days of the date of the request.

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

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

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

Binding Arbitration

Disputes between you and WHA are typically handled and resolved through the WHA's Grievance, Appeal, and Independent Medical Review processes. However, in the event that

a dispute is not resolved in those processes, WHA uses binding arbitration as the final method for resolving all such disputes.

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

This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter. WHA's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties.

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

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

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

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

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

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

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

Definitions

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

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

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

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

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

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

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

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

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

Disputed Health Care Service means any health care service eligible for coverage and payment under a health care service plan contract that has been denied, modified, or delayed by a decision of WHA, by one of its contracting Medical Groups or Participating Providers, due in whole or in part to a finding that the service is not Medically Necessary. A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage decision.

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

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

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

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

Emergency Services and Care also pertain to:

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

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

1. The Diagnostic and Therapeutic Technology Assessment Project of the American Medical Association;
2. The Center of Healthcare Technology;
3. The National Institute of Health;
4. The Federal Food and Drug Administration;
5. The specialty board and the academy it represents as recognized by the American Board of Medical Specialties (ABMS) or
6. An external Independent Review expert hired to review all appeals for investigational/experimental treatments.

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

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

Group Contract means the UC Health and Welfare Insured Plans — 2008 Standardized Contract between your employer and WHA.

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

Hospice Care means services provided by Participating Providers to Members who are certified in writing by a Participating Physician to be terminally ill (i.e. the Member's medical prognosis is that the life expectancy is one year or less), emphasizing supportive services and dietary counseling under the direction of a Participating Physician in accordance with a written plan of care, including but not limited to services that are home-based.

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

Independent Medical Review means a review that the Member has the opportunity to seek whenever health care services have been denied, modified, or delayed by WHA or by one of it contracting Medical Groups or Providers if the decision was based on a finding that the proposed services are not Medically Necessary. (Effective January 1, 2001)

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

Life Threatening means either or both of the following:

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

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

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

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

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

Medically Necessary means that which WHA determines:

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

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

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

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

Member Satisfaction Procedure means the process by which Members may communicate their concerns regarding their care either verbally or in writing, with WHA. Generally there are three categories as defined below:

- An **Appeal** is a formal request by a practitioner or Member for reconsideration of a decision, such as a utilization review recommendation, a benefit payment, an administrative action, or a quality-of-care or service issue, with the goal of finding a mutually acceptable solution.
- A **Complaint** is any written or oral expression of dissatisfaction and shall include any complaint, dispute, request for reconsideration or appeal made by a Member, the Member's representative or

Provider, about their experience with WHA, a Medical Group and /or any WHA providers.

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

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

Non-Preferred Medications means Generic Medications or Brand Name Medications that are not on the Preferred Drug List.

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

Orthotic Device means a rigid or semi-rigid device used as a support or brace and affixed to the body externally to support or correct a defect or function of an injured or diseased body part which is Medically Necessary to the medical recovery of the Member, excluding devices to enable the Member to participate in athletic activity, whether this activity is prior to any injury or as a part of the medical recovery service.

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

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

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

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

Participating Provider means a Participating Physician, Participating Hospital, or other licensed health professional or licensed health facility who or which, at the time care is provided to a Member, has a contract in effect with WHA to provide Covered Services to Members. Information about Participating Providers may be obtained by telephoning WHA at (916) 563-2252 or (888) 563-2252.

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

Physician means a duly licensed "physician and surgeon" under California law.

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

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

Primary Care Physician or PCP means a Participating Physician who:

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

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

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

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

Preferred Drug List (PDL) is a listing of medications developed by WHA's Pharmacy and Therapeutics (P&T) Committee as drugs of choice in their respective classes. WHA uses a 3-tier open formulary system. Preferred Generic Medications listed on the PDL are covered at the lowest copayment. Preferred Brand Name Medications listed on the PDL are provided at the second copayment level. Non-Preferred Medications are not listed on the PDL and are covered at the third tier copayment level but generally do not require a prior authorization. There are a small number of drugs, regardless of tier level that may require Prior Authorization to ensure appropriate use based on criteria set by the WHA Pharmacy and Therapeutics Committee. **Please note: the presence of a drug listed on the WHA PDL, does not guarantee that the Member's physician will prescribe the drug.** You may request a copy of the PDL by calling WHA Member Services at (916) 563-2252 or (888) 563-2252 or view the document on the Web page: westernhealth.com.

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

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

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

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

Provider Reimbursement means the contractual arrangement between WHA and the Participating Providers with which WHA contracts for the provision of covered benefits on behalf of the Members of WHA. The basic method of provider reimbursement used by WHA is "capitation": a per Member, per month payment by WHA to its contracted providers. Because WHA is a not for profit Plan, owned and directed by local healthcare systems, there are no bonus schedules or financial incentives in place between WHA and its contracted providers which will restrict or limit the amount of care which is provided under the benefits of this EOC/DF. For additional information regarding provider compensation issues, Members may request additional information from WHA, the provider or the provider's Medical Group or IPA.

Service Area means the geographic area in which WHA has been authorized by applicable regulatory agencies to provide routine Covered

Services to Members. See “WHA Service Area Zip Code List” section of this EOC/DF.

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

Serious Emotional Disturbances of Children or SED is present when a Member under 18 meets both of the following criteria: (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child’s age according to expected developmental norms; and (2) meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code (copy available through Member Services).

Severe Mental Illness means the following diagnoses: schizophrenia, schizoaffective disorder, pervasive developmental disorder or autism, obsessive-compulsive disorder, panic disorder, major depressive disorder, bipolar disorder (manic depressive syndrome), anorexia nervosa and bulimia nervosa.

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

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

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

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

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

WHA Service Area Zip Code List

Western El Dorado County:

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

Placer County:

95602 95603 95604 ***95631 (partial)** 95648 95650 95658 95661 95663 95677 95678
95681 95703 95713 95722 95736 95746 95747 95765

Sacramento County: All Zip Codes

Solano County:

94512 94533 94535 94571 94585 95620 95625 95687 95688 95694 95696

Yolo County: All Zip Codes

Colusa County:

95912 95931 95932 95950 95955 95957 95987

All subscribers and dependents must live or work within a WHA licensed zip code, meaning that either their primary workplace or Primary Residence is within a WHA licensed zip code.

*Call our Member Services Department at (916) 563-2252 or (888) 563-2252, to ensure your zip code is covered in our service area.

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Western Health Advantage

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beyond expectation

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